STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MI
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

A copy of the Assurances (Non-Construction Programs) and Certifications signed by the Director of the Department of Community Health may be obtained by contacting the Title V Director's Office at 517/335-8928.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Comments from the public were invited during the needs assessment process through advisory groups, advocacy organizations, consumer groups and professional associations and from provider agencies and other state departments. Comments on the draft application narrative were invited from local health departments and other contract agencies, advisory groups, other areas of the department with overlapping interest and the general public. The draft document was posted on the department's web site (www.michigan.gov/mdch, click on Pregnant Women, Children and Families) and a notice was published in four newspapers throughout the state (Detroit Free Press, Grand Rapids Press, Traverse City Record-Eagle, and Marquette Mining Journal).

No comments were received other than a few edits.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The Title V program in Michigan operates within the larger context of public health services as articulated in the Department of Community Health's mission statement: "...to promote access to the broadest possible range of quality services and supports; take steps to prevent disease, promote wellness and improve quality of life; and strive for the delivery of those services and supports in a fiscally prudent manner." To accomplish this mission, the department employs a variety of resources including federal, state and local funding to provide, arrange or assure access to a broad range of health and other social services. Services are arranged and delivered at the community level through a variety of public and private agencies, including local health departments, hospitals, clinics, private practices, schools, Planned Parenthood organizations, migrant health centers, and primary care centers. Cooperative efforts to achieve specific initiatives are arranged with the private sector, such as managed care plans, universities, Delta Dental of Michigan, Blue Cross/Blue Shield of Michigan, Michigan State Medical Society, and Michigan Association of Broadcasters. Within the Department of Community Health, Title V programs and planning and policy activities are coordinated with the Medicaid program, MIChild (state CHIP), mental health and substance abuse services, chronic disease programs, communicable disease programs, and injury prevention programs.

The Title V program also works with other state departments on initiatives that affect our mutual customers. One current initiative is the development of a comprehensive early childhood system of care (ECCS). This initiative is funded in part by a grant from HRSA and is part of the Governor's Great Start Initiative which aims to get children to school ready to learn. The Title V Director is the project officer for this grant. The Great Start Initiative is guided by the Children's Cabinet, consisting of the Directors of the Departments of Community Health, Education, Human Services (formerly Family Independence Agency), and Labor and Economic Growth. The Children's Action Network (CAN) is appointed by the Children's Cabinet to focus on prevention and early intervention services for children 0-5 years of age. In addition to members of the Children's Cabinet, CAN includes representatives of advocacy groups and other key state staff. The ECCS project is now completing planning activities and has applied for an implementation grant that would start in September 2005. Through this network, the Title V program also works with interagency staff on the development of Family Resource Centers in schools that have been designated as "priority" based on their Annual Yearly Progress status under No Child Left Behind.

The public health functions of assessment and assurance are shared between the Department of Community Health and local health departments (LHD). Under the Public Health Code, all counties are required to provide for a local health department and are charged with: prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable populations; development of health care facilities and services delivery systems; and regulation of health care facilities and services delivery systems to the extent provided by law. There are 30 single county health departments, 14 district health departments covering multiple counties, and one city health department. See Section III.E below for further discussion of the role of local health departments.

According to the 2000 Census, Michigan has the eighth largest population in the United States. In 2003, the total estimated population in Michigan was 10.079,985 according to the US Census Bureau. This includes 126,553 infants, 521,204 children 1-4 years of age, 2,179,219 children 5-20 years of age, and 2,125,430 women of childbearing age (15-44 years). Approximately 78% of infants were white, 18.9% black, 2.7% Asian and Pacific Islander, and less than 1% were American Indian. Of Michigan residents aged 1-20 years, 78% were white, 18.7% were black, 2.4% were Asian/Pacific Islander, and 0.9% were American Indian. Among women of childbearing age, 82% were white, 16% were black, 1.7% were Asian/Pacific Islander, and 0.8% were American Indian. Minority populations are increasing in proportion to the total population of the state.

There were 130,850 resident live births in 2003. Between 1998 and 2003, the number of live births declined by 2.1 percent. The fertility rate (per 1000 women) for women aged 15-19 years declined by

19.6% from 1999 to 2003, while the overall fertility rate increased for the same period by 2.2%.

In 1999, over 3.2 million Michiganians were medically underserved and over 1.5 million were unserved. Rural residents had a slightly greater risk for being without health insurance than urban residents. However, almost nine out of ten residents (87.9%) without health insurance coverage live in urban areas. Michigan has a lower percentage of uninsured residents on average than the United States, but has over 1.1 million uninsured residents. Residents at greatest risk of being uninsured are young adults (particularly those ages 21-24), minorities and working poor (less than 200% of poverty).

According to the 2000 U.S. Census, 74.7% of the state's population resides in urban areas, up from 70.5% in 1990. However, only 25 of the state's 83 counties are classified as Metropolitan Statistical Counties. All specialized health care facilities are located only in urban areas, making it difficult for rural residents to access those facilities. Rural road conditions when it rains or snows heavily also create barriers to accessing care, particularly in the Upper Peninsula. Another access problem is created by the fact that the sole ground connection between the Upper and Lower Peninsulas is via the Mackinac Bridge which may be closed during windy, foggy and icy conditions.

Language is another potential barrier to access to care. An estimated 8.4% of persons age 5 and over speak a language other than English at home. Of these, 2.7% speak Spanish, 1.1% speak an Asian or Pacific Island language, and 3.3% speak other languages.

According to the Division for Vital Records and Health Statistics, MDCH, the five leading causes of death in 2003 for Michigan were: heart disease; cancer; stroke; chronic lower respiratory diseases; and accidents. Among whites and blacks of both genders, the leading causes of premature death were predominantly due to chronic illnesses. However, homicide is the second leading cause of premature death and the third leading cause of overall death in black males. Heart and lung problems were among the four leading causes of preventable hospitalizations among Michigan residents. Over 19% of Michigan residents have some type of disability, which is higher than the United States. Detroit is estimated to have one in four persons with some type of disability. For Michigan children under 1 year of age, the leading causes of death are conditions originating in the perinatal period, congenital malformations, accidents, SIDS and diseases of the heart. The majority of postneonatal deaths are due to preventable causes. For Michigan children 1 year of age and over, the leading cause of death by far is unintentional injuries. Other leading causes for this age group are homicide and cancer.

Michigan has been facing severe socioeconomic challenges over the past few years, as illustrated by increasing unemployment rates. From 1992 to 2001, Michigan employment grew by only 16.8% compared to national employment growth of 22.3%. The state's 2003 average annual unemployment rate rose to 7.0%, up from 6.2% in 2002. From December 2002 to December 2003, Michigan wage and salary employment declined by 79,000, or 1.8 %. Nationally, December wage and salary employment fell 0.1% from a year earlier.

Since 2001, Michigan has had a cumulative deficit of over $7.8 billion and has cut spending by approximately $3 billion. Both a lagging economy and a structural imbalance between revenues and expenditures have contributed to the state's budget problems over the past four years. Manufacturing is a significant component of Michigan's economy and its recovery is lagging behind the overall economic recovery. Tax reductions have contributed to the decline in state revenues, even as the demand for public services has increased. Costs continue to rise annually for Corrections, health care for public employees and Medicaid. The Medicaid caseload has grown from just over 1 million in 1999 to almost 1.4 million in 2004.

According to the 2000 Census, there were 192,376 families, or 7.4% of all families, who were below the 100% poverty level. This is down from 10.2% of all families in the 1990 Census. In families with related children under 18 years of age (2000 Census), 11.3% lived in poverty and 14.7% of families with related children under 5 years were below poverty. Among the white population, 9.5% of children under 18 and 12.0% of children under 5 were below the poverty level. Among black children, 39.5% of

children under 18 and 49.5% of children under age 5 were below the poverty level. For the American Indian and Alaska Native population, 39.0% of children under 18 and 16.1% of children under 5 were below poverty. For the Asian population, 12.3% of children under 18 and 7.5% of children under 5 were below poverty.

While Michigan has high numbers of persons with insurance coverage, many residents are uninsured or underinsured and are unable to consistently access quality healthcare. Medicaid provides coverage for approximately 10% of Michigan's population, but residents still face other challenges in accessing healthcare. For example, recruitment and retention of medical personnel, particularly nurses, is a growing problem. The WIC program currently serves over 41% of all births in Michigan and over 70% of African American and Hispanic births.

The Department's current priorities include implementing the recommendations of the Mental Health Commission, reduction of health disparities, implementing legislative changes regarding childhood lead poisoning, promoting healthy lifestyles of Michigan residents through the Michigan Steps Up Initiative, and reducing unintended pregnancies and infant mortality. The Title V program has been working with the Governor's Office, the Bureau of Epidemiology and Medical Services Administration to implement electronic reporting of blood lead analyses and a lead-safe rental housing registry, increase testing levels of children in the Medicaid program, establish and implement penalties for landlords who knowingly cause lead poisoning of children and to establish and appoint a state Lead Commission. The Title V program has been working with the Medical Services Administration to obtain a 1115 waiver from the Centers for Medicare and Medicaid Services to extend family planning services to women whose pregnancy and delivery were covered by Medicaid and have no other source of coverage. The Title V program also participates in the Department's health disparities reduction efforts through infant mortality initiatives and the childhood lead poisoning prevention program.

B. AGENCY CAPACITY

The primary authority for maternal and child health programs in the state is the Public Health Code (P.A. 368 of 1978, as amended). Part 23 of the Code requires the Department to identify priority health problems and develop a list of basic health services to be made available and accessible to all residents in need of the services without regard to place of residence, marital status, sex, age, race, or inability to pay. The current list of designated basic health services is: immunizations, communicable and sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, newborn screening for eleven conditions, health/medical annex of the emergency preparedness plan, and prenatal care. Part 24 of the Code spells out the authority and responsibility of local health departments. Section 5431 requires screening of newborns for PKU, galactosemia, hypothyroidism, maple syrup urine disease, biotinidase deficiency, sickle cell anemia, and other treatable but otherwise handicapping conditions as designated by the department. Part 58 of the Code authorizes the department to establish and administer a program of services for children with special health care needs. Section 9101 requires the department to establish a plan for school health services in cooperation with the Department of Education. Section 9131 requires the department to publicize places where family planning services are available. Part 92 authorizes and sets certain requirements for immunization. Part 93 establishes a program of hearing and vision screening for children.

The Michigan Legislature passed P.A. 167 in 1997 supporting statewide development of child death review teams. The law also defined the composition of the teams, established reporting requirements, provided for training and technical assistance and exempted team meetings from FOIA. New legislation was passed in 2004 regarding lead poisoning. A package of six bills established a lead-safe rental housing registry and state lead commission appointed by the Governor, mandated electronic reporting of blood lead analyses, required Medicaid providers to increase testing levels of children and established penalties for landlords who knowingly cause the lead poisoning of children.

Most programs are operated by local health departments, qualified health plan (managed care) providers, hospitals and other community health care providers. The department contracts with these agencies to provide services based upon needs identified at the state or local level, utilizing a combination of state funds, Title V, Medicaid and fees.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Newborn Screening Program currently screens for eleven disorders: PKU, galactosemia, hypothyroidism, MSUD, biotinidase deficiency, sickle cell anemia, congenital adrenal hyperplasia, MCAD deficiency, homocystinuria, citrullinemia and ASA. Blood samples are submitted by hospitals to the state laboratory which analyzes the samples and reports the results to the Newborn Screening Program. Program staff follow up on all positive or unsatisfactory test results with hospitals, family or family physician. MDCH contracts with three medical centers to assure and/or provide comprehensive diagnostic and treatment services. A statewide pilot was initiated in May, 2005 to expand newborn screening from the current panel of eleven disorders to 40 disorders, including fatty acid oxidation and organic acid disorders. The pilot will evaluate the feasibility of detecting disorders early and ensuring appropriate follow-up systems are in place to manage diagnosis and treatment.

The Hereditary Disorders Program (HDP) coordinates statewide services for genetic diagnosis and counseling, and provides information about birth defects and inherited diseases. Six regional coordinating centers are funded to provide a network of clinics for diagnosis, counseling and medical management, and to provide outreach education to community groups, including families, health professionals and teachers. HDP staff members and the Michigan Birth Defects Registry (MBDR) participate in a cooperative agreement with the Centers for Disease Control and Prevention (CDC) for birth defects surveillance and utilization of data for public health programs relating to prevention and intervention.

The Nurse Family Partnership is a nurse home visiting program for first time, low-income pregnant women that has evidence of success addressing the family needs over approximately two and a half years. This service model has shown improved family outcomes, strengthening the environments of infants and young children, ultimately improving infant survival and young children's health. Services are provided through a team (four nurses and a part-time nurse supervisor). Each nurse maintains a caseload of 25 families. Nurses follow program guidelines that focus on the mother's personal health, quality of care giving for the child, and parents' own life-course development. Nurses involve the mother's support system including family members, fathers when appropriate, and friends, and they help families use other health and human services they may need. Four communities with significant disparity are currently implementing this model. These communities had other related factors such as having at least 100 African American first time, low-income births, lower high school completion rates, a significant number of young children living in poverty, etc.

The Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Services are delivered through local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.

The Fetal Alcohol Syndrome (FAS) program has three main components: 1) five multidisciplinary teams called Centers of Excellence diagnose children and provide initial care planning; 2) eleven community projects provide community outreach and education; and 3) training and consultation to assist collaborative agencies in their work. This work is guided and assisted by FAS steering committees and community networking to increase awareness of FAS and the importance of its prevention, do outreach, screening and referrals to diagnostic services, and assist with providing therapeutic and social supportive services to families and children with FAS. These projects vary in their delivery method, but include working extensively with other programs such as Early On, WIC, foster care, substance abuse programs, Infant Support Services, Family Independence Agency case workers, as well as community partners such as liquor stores, restaurants, media companies, etc. The

Department provides funding for the projects, training and assistance with building community awareness.

The Fetal-Infant Mortality Review (FIMR) Program is supported by state funds to build FIMR capacity through local team development, technical assistance, consultation, training, data collection, research design, and program evaluation. Currently, teams are operating in Berrien County, Branch County, Calhoun County, City of Detroit, Genesee County, Jackson County, Kalamazoo County, Kent County, Lapeer County, cities of Pontiac and Southfield in Oakland County, Saginaw County and Washtenaw County and a team to study Native American infant deaths statewide. No funds for local teams have been available since 9/30/2001.

Infant Support Services, funded by Medicaid, provide non-medical support services consisting of health education, parenting education, breast-feeding education, counseling in appropriate infant care, nutrition, social casework, infant mental health, transportation, care coordination, referral and follow-up. Services are targeted to high-risk Medicaid-eligible infants and their families. Infants are referred when one or more of the following risk factors is present: abuse of alcohol or drugs or smoking; mother is under the age of 18 and has no family support; family history of child abuse/neglect; low birth weight; mother with cognitive, emotional or mental impairment; homeless or dangerous living situation; or any other condition that may place the infant at risk of death, significant impairment or illness. A team of professionals including a nurse, nutritionist and social worker provide the services. An infant mental health specialist is an optional member of the team.

The Maternal Support Services Program provides nutrition, psychosocial, nursing and transportation services to Medicaid-eligible, high-risk pregnant women. The high-risk factors are: unstable or non-existent social support systems; history of child abuse/neglect; negative feelings/attitudes toward the pregnancy; unstable emotional status/inability to cope; educational/developmental deficits; dysfunctional family/domestic violence; and nutritional deficits.

The Maternal and Child HIV/AIDS Program assures that coordination of existing medical care and social support services exists for families living with HIV/AIDS in southeast Michigan. The program follows a family-centered approach to service delivery, employing a family case manager to link families with needed care across service systems. The target populations are women, adolescents, children and families with HIV, and sexually active women and youth. Clients receiving services from contracted agencies have access to primary and tertiary care for HIV disease and may also receive the following services: comprehensive, coordinated, family-centered care and case management services; access to an emergency fund for eligible expenses; gynecological services; psychosocial services; information and access to available clinical trial participation; opportunities to participate in a community advisory board; child care resources; transportation; resources to enhance development of leadership skills in women and/or adolescents affected by HIV; and health education, information and referrals for other health and psychosocial services.

The Newborn Hearing Screening Program is a hospital-based, voluntary program to screen newborns for hearing loss by one month of age, assure diagnosis by the age of three months, and, when appropriate, assure intervention services by the age of six months. The department provides education to local health care facilities on the importance of newborn hearing screening, the need for a collaborative local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. As of April, 2004, all Michigan birthing hospitals are participating in the screening program.

The Prenatal Smoking Cessation Program works with low-income pregnant smokers who are receiving health services in public prenatal programs. Intervention is based on a stages of change model.

The Michigan Sudden Infant Death Services Program covers all sudden infant deaths during the postneonatal period, which are not trauma, homicide or chronic illness. To improve the capacity to provide bereavement services, new cases are being reported to the Michigan SIDS Alliance which

sends a grief literature packet and makes referrals for grief support. Bereavement support education is provided. A Family Services Committee of bereaved parents acts as an advisory group to the Family Support Coordinator. To help coordinate infant mortality reduction efforts, the SIDS Alliance staff were given positions on the state Fetal-Infant Mortality Review Network, the state Infant Mortality Network and the local FIMR and Child Death Review teams.

Preventive and Primary Care Services for Children

The Michigan Abstinence Partnership aims to positively impact adolescent health problems through promoting abstinence from sexual activity and the related risky behaviors such as the use of alcohol, tobacco, and other drugs. A comprehensive approach targeting 9 to 17 year old children and their parents is used and includes coalition development, community activities, media, and educational and promotional items. Educational materials promote the abstinence message and efforts of the partnership. The media campaign has been developed targeting 9 to 17 year old children through television, radio, and posters. Technical assistance is provided to assist with local partnership activities, coalition building, program development and evaluation.

The Adolescent Health Program includes two models of service delivery -- adolescent health centers and alternative models. The adolescent health center model provides on-site primary health care, psychosocial, health promotion and disease prevention education, and referral services. The alternative model focuses on case finding, screening, referral for primary care, and providing health education services. The program administers 33 child and adolescent clinical health centers and 12 non-clinical centers. In November 2001, the program funding source was shifted to the School Aid Fund in the Department of Education. The Department of Education contracts with the centers and the Department of Community Health continues to provide monitoring, training, technical assistance and consultation

The Oral Health Program provides consultation, technical assistance, and statewide coordination for oral health programs to local health departments (LHDs) and other community agencies. Forty-six local agencies, including LHDs, primary care centers, migrant health clinics, and Indian Health Services (IHS) conduct public health dental programs. Forty-three provide direct clinical services and three programs refer to private dental offices. One LHD program is supported by funding from the MCH block grant to provide dental care to dentally underserved children in a five county area. Other programs are funded locally, through fee-for-service collection, Medicaid, private foundation funds, and federal funding (IHS, primary care, and migrant health). A network of volunteer dentists provides dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly, through the Donated Dental Services Program, supported by the Healthy Michigan Fund. The department provides dental services to the developmentally disabled population who are not eligible for Medicaid, cannot access a Medicaid provider, do not have other dental coverage, and cannot afford dental care. Services provided are limited to the treatment of those conditions that would lead to generalized disease due to infection or improper nutrition.

The Hearing Screening Program supports local health department (LHD) screening of children at least once between the ages of three and five years and every other year between the ages of five and twelve years. A few LHDs also screen children younger than three utilizing a subjective behavioral technique which rules out a severe profound hearing loss. LHD staff are trained as either an EPSDT technician or a comprehensively trained school screening technician. Quality assurance is provided for approximately 200 LHD threshold technicians by the MDCH audiology consultant, through field visits and required biennial skills update workshops. Over 680,000 children are screened per year in preschool and school programs. Increasingly, agencies are utilizing otoacoustic emissions (OAE) technology, for screening young children and children who are difficult to test. Follow-up for all referred children is required to assure that needed care has been received, or assistance given to be seen at an Otology clinic provided through CSHCS. Most screenings are conducted in schools and day care centers.

The Childhood Lead Poisoning Prevention Program (CLPPP) supports the coordination of lead

poisoning prevention and surveillance services for children in Michigan and the funding of pilot sites for primary prevention of lead poisoning through the identification of lead hazards in housing. Infants, children under six years, and pregnant women are priorities for screening and testing. Program service components are education and outreach, blood screening and testing, tracking, reporting, primary prevention activities, policy development and program management, quality assurance, and evaluation.

Vision screening of pre-school children is conducted by local health department (LHD) staff at least once between the ages of three and five years, and school-age children are screened in grades 1,3,5,7,9,11 or in grades 1,3,5,7, and in conjunction with driver training classes. Screening, re-testing and referral is done. The battery of vision screening tests is administered by LHD staff trained by the Vision Consultant in the Division of Family and Community Health at MDCH. Consultation and quality assurance is provided for the approximately 200 LHD school screening technicians by the MDCH Vision Consultant and a cadre of specially trained individuals, through field visits and skills update workshops provided yearly in at least three regional sites. Follow-up for all screening is required which assures that care is received. More than 850,000 preschool and school-age children are screened each year and more than 70,000 referrals are made to eye doctors annually.

Services for Children with Special Health Care Needs

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (e.g., hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or surgical specialists. The program also evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric subspecialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: casefinding; application for CSHCS coverage, assessment of family service needs, and service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports.

Medical care and treatment includes a wide range of services such as physician specialist care, hospitalization, pharmaceuticals, special therapies and durable medical equipment, home health nursing, and orthotics/prosthetics. In addition to making payment for these services, CSHCS assures quality in the services provided. Physicians, hospitals, and clinics must meet established criteria in order to qualify as CSHCS "approved" providers. The criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, CSHCS authorizes specific providers for each child, so that specialty expertise is appropriate for the child's condition. Provider reimbursement policies and rates are the same for both CSHCS and Medicaid.

There are no fees assessed for families whose income is at or below 250% of the federal poverty level or for children adopted with a qualifying pre-existing condition. All other families are required to have their income evaluated. Families can choose to participate in the program, subject to a payment agreement established on a sliding-fee scale.

CSHCS is a statewide program, although certain program components may not be located in every county. For example, children's multidisciplinary clinics are associated with tertiary care centers, and family support coordinators may serve more than one county.

Local health departments (LHDs) serve as a community resource to assist families in accessing needed services, both from CSHCS and other local agencies. LHD CSHCS professionals are encouraged to work closely with their MCH colleagues and with other agencies to identify community service needs from the perspective of children with special health needs and their families. These local collaborative efforts are supported by the state-level approach to community needs assessment and are reflected in efforts to remove artificial, categorical barriers to services. Local efforts are

focused on the earliest intervention possible to prevent, cure or minimize the impact of handicapping conditions on children. In addition to program representation activities for the purpose of casefinding, the LHD system or the CSHCS Customer Support Section helps families to obtain needed program information and services. Families are offered a Family Service Needs Summary by the LHD when the family requests assistance in understanding the CSHCS program and other services available in their communities. During the service needs summary, LHD professionals help to identify the needs of all family members. Service coordination (formerly case management) can then be provided if the family decides it wants further help in developing self-advocacy skills, problem-solving, or in obtaining needed services.

The CSHCS program operates according to the philosophies inherent in Family-Centered, Community-Based, Culturally Competent, Coordinated Care. This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure that assures both input and feedback with regard to these critical program characteristics. The Parent Participation Program (paid parent consultants to the program), parent membership in the CSHCS Advisory Committee, and the Family Support Network are program elements that reinforce family-centeredness. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

The Parent Participation Program has three major areas of responsibility: 1) development of a statewide, community-based network of parent-to-parent support, 2) provision of parental input to CSHCS administration regarding programs and policies; and 3) facilitation of timely responses to families in need. As a core component of the CSHCS organization, the program is headed by a parent of a child with special health needs. The program is unique in that it is inclusive of all families of children with special health care needs, whether or not they are enrolled in CSHCS. The Children's Special Health Care Services hotline is operated through the Parent Participation Program.

All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS as the circumstance arises.

C. ORGANIZATIONAL STRUCTURE

The Michigan Department of Community Health is the state public health agency, responsible directly to the Governor. The Department is organized into six administrations, five programmatic and one administrative support: Medical Services Administration, Health Policy, Regulation and Professions Administration, Public Health Administration, Mental Health and Substance Abuse Administration, Office of Services to the Aging, and Administrative Operations. The Medical Services Administration has primary responsibility for the Medicaid and state CHIP program, MIChild. The Health Policy, Regulation and Professions Administration includes licensing functions for health care professions and health care facilities which were transferred into the Department by Executive Order in December, 2003.

The Public Health Administration includes the Bureau of Family, Maternal and Child Health (BFMCH), Bureau of Laboratories, Office of Public Health Preparedness, Bureau of Health Promotion and Disease Control, and the Bureau of Epidemiology. Responsibility for Michigan's Title V program is placed within the Public Health Administration, Bureau of Family, Maternal and Child Health. The Title

V program works closely with the Epidemiology Bureau on maternal mortality and other MCH epidemiology studies using state vital records, PRAMS and other health statistics, newborn screening and hereditary disorders. BFMCH coordinates activities with the Chronic Disease Division around childhood obesity, childhood injury, suicide and breast and cervical cancer. BFMCH works with the Bureau of Laboratories on childhood lead poisoning, immunizations and sexually transmitted diseases. BFMCH also works closely with the Medical Services Administration on Medicaid and MIChild coverage of services to women and children and coordination of eligibility determination and payment for services to children with special health care needs.

The Bureau of Family, Maternal and Child Health includes the Division of Family and Community Health, Children's Special Health Care Services Division, and the WIC Division. Because the WIC program reaches so many low-income families, it is integral to many of our MCH efforts including promotion of immunization, lead poisoning screening, nutrition and breastfeeding. Children's Special Health Care Services provides medical care and treatment, care coordination and other ancillary services for children with special health care needs and works closely with the Medical Services Administration in providing specialty services for Medicaid-eligible families and coordinating with primary care services. The Division of Family and Community Health (DFCH) includes several programs targeting birth outcomes and child health including childhood lead poisoning prevention, adolescent health centers, Michigan Abstinence Partnership, School Health, Oral Health, Newborn Hearing Screening, Nurse/Family Partnership projects, Maternal and Infant Support Services, Family Planning, SIDS and Other Infant Deaths, Fetal-Infant Mortality Review projects, Fetal Alcohol Syndrome and Prenatal Smoking Cessation. DFCH works with the Medical Services Administration on Maternal and Infant Support Services and coverages for other maternal and child health services. The divisions contract with local health departments, private clinics and physicians, FQHCs and other providers to implement maternal and child health services at the community level.

D. OTHER MCH CAPACITY

The department does not provide direct services, but contracts with local health departments and other community health agencies to provide MCH services. Department staff provide training, consultation and technical assistance to local staff in various programs, certify providers of Maternal and Infant Support Services, determine eligibility for CSHCS program, plan and develop programs, projects and new initiatives, and monitor the performance of local programs. Most of the staff at the state level working on Title V programs are located in the divisions of Family and Community Health and Children's Special Health Care Services.

In the Division of Family and Community Health, there are approximately 46 professional (including vacancies and contractual positions) and 7 support staff working on programs for pregnant women, mothers, infants, children and adolescents. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers.

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division includes 29 professional and 11 support staff. Staffing includes nutritionists, analysts and managers.

The Children's Special Health Care Services Plan Division currently includes approximately 30 professional and 15 support staff. Professional staff is made up of doctors, nurses, nutritionists, analysts and managers. Support staff perform clerical, technical and enrollment functions. Parents of children with special needs, working through the Parent Participation Program, perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Parent Participation Program (PPP) employs 9 staff persons, 5 of whom are parents of children with special needs.

Kathleen Stiffler is the Director of the Children's Special Health Care Services Division. Ms. Stiffler has 17 years of experience in various capacities within the Maternal and Child Health area. Most recently she served as the Unit Director for Adolescent Health for over eight years. In that capacity

she was responsible for directing program and policy development, program implementation and monitoring, quality assurance, evaluation and program improvement for Michigan's adolescent health programs. The focus of adolescent health programming in Michigan includes school-based/school-linked teen health centers (primary care programs designed to address the unique needs/strengths of the adolescent-aged population) and teen pregnancy prevention. Prior to that, Ms. Stiffler was the Chief of the Prenatal and Infant Care Section. Ms. Stiffler holds a Master's Degree in Health Education from Central Michigan University.

Douglas M. Paterson is Director of the Bureau of Child and Family Programs within the Michigan Department of Community Health. In this capacity, he oversees the WIC Division, the Children's Special Health Care Services Division, and the Division of Family and Community Health. Mr. Paterson has 30 years of experience in Maternal and Child Health serving as the WIC Director and Division Director over several MCH Programs. He currently serves as the Title V MCH Director for the State of Michigan and Project Manager for the State MCH Early Childhood Comprehensive Systems Grant. Mr. Paterson has a Master's Degree in Public Administration.

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and two physicians who dedicate a portion of their efforts toward CSHCS needs. Their role is determination of program eligibility, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary.

The Newborn Screening and Hereditary Disorders Program within the Bureau of Epidemiology has seven professional and two support staff. Professional staff includes a public health consultant who directs the NBS Follow-up Program component and a public health consultant who serves as State Genetics Coordinator. In addition, the program contracts with 2.5 FTE nursing/genetics professionals for projects related to birth defects, newborn screening, and adult genetics, as well as two parent consultants funded through grants on an hourly basis.

The Bureau of Epidemiology also includes 2 epidemiologists dedicated to maternal and child health issues and work with the Bureau of Family, Maternal and CHild Health on data collection and analysis and evalutation.

E. STATE AGENCY COORDINATION

The Michigan Department of Community Health includes administrations responsible for the Medicaid and MIChild programs, Mental Health and Substance Abuse, Public Health, Services to the Aging, and licensing of health professionals and facilities. In administering the Medicaid and MIChild programs, DCH works closely with the Department of Human Services, the state agency responsible for eligibility determination for Medicaid and other assistance programs.

Directors of the Departments of Community Health, Education, Human Services, and Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting their common target populations. In March, 2003 the Governor created the Children's Action Network (CAN) consisting of directors of all state departments that have services to children and families within their purview. The purpose of CAN is to coordinate child and family programs across state agencies and implement a shared policy agenda promoting health, social and emotional development and school readiness in all young children. In addition, the departments of Community Health, Human Services, Education and Labor and Econimc Growth are collaborating on the Early Childhood Comprehensive Systems Planning Project, begun in 2003 with a grant from MCHB. Along with parents, providers, community representatives and advocacy organizations, this project is developing a plan for the structure, finance, performance measures and program strategies for implementing a comprehensive system of care for children 0-5 years of age that supports early brain development. Staff members from the human services agencies guide the project and report to the Children's Action Network on progress and products. The project is coordinated with the Governor's Great Start campaign to get children to school ready to learn.

DCH and the Department of Human Services (formerly the Family Independence Agency) continue to work together on outreach activities to low-income families eligible for public programs. The Department of Human Services (DHS) provides information and helps families apply for Medicaid and MIChild, determines Medicaid eligiblity and updates relevant information for Medicaid beneficiaries. DCH and DHS collaborate on policies and processes for making low-income families aware of their eligibility for public assistance programs through various state and local sources, particularly families leaving the TANF program due to increased income or noncompliance with work requirements. DCH and DHS also collaborate on family preservation efforts, the Safe Delivery program targeting new mothers who may want to surrender their babies, and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team. In addition, WIC and DHS coordinate annual outreach campaigns for the WIC nutrition and TANF programs. WIC and DHS also co-locate services in the Detroit and Wayne County area to increase enrollment of the eligible population in those areas.

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council. The departments also cooperate in administering the Youth Risk Behavior Survey and the School-based Health Centers. Through the Children's Action Network, DCH works with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind.

DCH joined with the Departments of Agriculture and Environmental Quality in developing and implementing the Michigan Local Public Health Accreditation Program. This program institutes a baseline standard for characteristics and services that define a local health department. The program includes a self-assessment and on-site review components and is operated on a three-year cycle. DCH contracts with the Michigan Public Health Institute to house, staff and coordinate the program. More information on this program can be found at www.accreditation.localhealth.net.

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local Public Health Accreditation Program); developing new programs and projects (e.g., Suicide Prevention, Safe Delivery, child death review teams); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans (QHPs). Most local health departments no longer provide EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). The state health department has responsibility for general supervision of the interests of the health and life of the people of Michigan, promoting an adequate system of community health services throughout the state, and developing and establishing arrangements and procedures for the effective coordination and integration of all public health

services, including effective cooperation between public and non-public entities to provide a unified system of statewide health care. With the responsibility for many personal care services including maternal and child health services shifted from local public health to qualified health plans, the role of local health departments has changed somewhat to emphasize assurance of community capacity to provide needed services and accountability for the health status of the community. LHDs continue to carry out the core functions and to provide services aimed at communicable disease control, protection of food and water supply, casefinding and service coordination and planning for children with special health care needs, health education and public information. In addition, the LHDs provide a link to other social and public services. The state health department supports the local health system with funding, training, technical assistance and data resources.

Building Bridges is a collaborative effort between local health departments, Medicaid Health Plans and state MCH programs to coordinate outreach efforts to pregnant women and children by increasing access and adequacy of care. A second annual Building Bridges meeting of stakeholders was held in June 2003. The Building Bridges Project meets quarterly to discuss access to care issues between Medicaid Managed Care, health departments and Maternal Support Services.

WIC is part of the Bureau of Family, Maternal and Child Health and continues to be an important component of strategies to improve the health of pregnant women, mothers and children. WIC clinics routinely make referrals for lead screening, maternal and infant support services, and prenatal smoking cessation. The clinics also routinely check immunization status and either refer or provide immunizations on site. Outreach activities are coordinated through the MCH hotline.

Availability and accessibility of family planning services is a key strategy for reducing unintended pregnancy and teen pregnancy. Resources of Title X, Preventive Block Grant and state funds are combined to assure that women and men in need of family planning services have access to them through a provider of their choosing and through referral arrangements with prenatal care providers, WIC and substance abuse programs. Family planning services are a required component of capitated funding for Medicaid enrollees in qualified health plans. The QHPs are also required to reimburse other publicly funded family planning clinics for family planning services provided to any QHP enrollee. The Division of Family and Community Health provides continuing education and training to Title X family planning clinics and managed care providers. The Family Planning program also works with the Breast and Cervical Cancer Control Program (BCCCP) to provide follow-up diagnosis and testing for women who had an abnormal Pap test from Family Planning services. This group of women is too young for the services of the traditional BCCC program.

There are currently five Healthy Start programs in Michigan. The department initiated a collaborative network of all programs to share their experiences, discuss issues of mutual concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance and supports an extensive program evaluation project in Detroit.

The implementation of Medicaid managed care has significantly changed the role of local health departments and the MCH program in assuring access to prenatal care. Qualified health plans are held accountable by contract for providing prenatal services in accordance with standards set by the Medicaid program. A separate organization is contracted to conduct enrollment activities. The Medical Services Administration is responsible for administering the managed care contracts, establishing performance standards, monitoring and evaluating performance. MSA contracts with the Michigan Peer Review Organization to conduct annual performance reviews of all plans. Many local health departments (LHDs) and community agencies continue to provide enrollment and outreach services to low-income women either through agreement with the QHP(s) in their area or with their own resources. Several have had to limit their activity due to funding constraints by reducing staff dedicated solely to enrollment and outreach or by concentrating on the non-Medicaid eligible low-income population. Local health departments are encouraged to partner with community agencies to extend the scope of their efforts.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Asthma remains a leading cause of preventable hospitalizations for children 1-5 years of age. There was a slight decline in the hospitalization rate in 2002. Data for 2003 and 2004 are not yet available.

The percent of Medicaid enrolled infants who received at least one periodic screen (Indicator #02) has improved since 1998. The Bureau of Children and Family Programs continues to work with Medicaid managed care to improve the numbers screened in the plans through establishing standards and quality assurance. Programs funded by MDCH which serve Medicaid eligible populations include requirements that providers assist women in using health care services for which they are eligible.

Encounter data for SCHIP enrollees is being collected in 2003 for the first time. Data for 2002 (Indicator #03) is not available. Unexpected problems in linking private provider service data and the MI Child enrollment data occurred and MI Child encounter data is just becoming available.

Indicator #05, comparing the Medicaid to non-Medicaid population, show the disparity between the two groups. The Medicaid population fared worse than the non-Medicaid population for indicators of low birth weight, infant mortality, infants born to women beginning prenatal care in the first trimester and pregnant women with adequate prenatal care. In spite of state efforts to remove barriers to accessing early prenatal care, the numbers beginning care in the first trimester continued to decline until 2001. In 2001 a policy change allowed the choice to stay with a Fee for Service provider and provided a guarantee of payment letter. Data on the percent of infants born to women who began care in the first trimester show some improvement in 2002 and 2003. Efforts to address this issue are described in Section IV. C, NPM #18 and Section IV. D, SPM #01. See also discussion on low birth weight under Section IV. C, NPM #15 and Section IV. D, SPM #03.

During 2002, MDCH contracted with 18 health plans to provide managed care services to more than 831,000 Michigan Medicaid enrollees. The HEDIS performance measurements were used to evaluate 15 components, including Access to Care. In 2003, the Access to Care results showed poor performance with all six rates falling below the national 2002 50th percentile. Recommendations were made that all health plans provide an analysis of barriers to care. Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care. Provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services and practice environments that fail to facilitate prevention. System barriers can include lack of resources or attention devoted to prevention, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care.

During the past three years an interactive forum called Building Bridges: Assuring Continuity of Care for Medicaid Beneficiaries through Collaboration, has been convened on several occasions to promote awareness and understanding of maternal and child health care outreach activities and to find creative solutions to barriers. The primary targets of this activity were local health departments and managed care providers. A report of the forum goals, objectives and outcome was published in September 2002, noting that 12 of the 19 Medicaid Health Plans participated as well as 32 of the 45 local health departments. Linkages between Medicaid Maternal Support Services, Infant Support Services, EPSDT and WIC were the most obvious collaborative outcomes as reported on evaluation surveys. In 2003 a forum has held to address collaborative outreach at a broad systems level and to present successful real world models for improving access to care. The collaborative approaches are being continued through a meeting of partners in health departments, health plans and state-level Medicaid policy makers. The focus is on identification of new pregnancies through WIC referral.

Infant mortality data also reflects the disparity between white infants and African American and Native American infants for SIDS. Safe Sleep messages have been devised to address sleep position, bed sharing, soft bedding, adult beds and couches. See Section IV. D, SPM #01 for further discussion.

As shown on Form 18, the Medicaid income eligibility levels for pregnant women and infants is up to 185% of poverty and up to 150% poverty for children 1-19 years of age. The Michigan SCHIP program, MIChild, serves pregnant women, infants and children 1-19 years of age whose family income is up to 200% of poverty.

Over the past five years, the department has been involved in the development of a linked data warehouse. The data warehouse, entitled the Executive Information System, Decision Support System(EIS/DSS), includes data from many of the MCH programs as well as the Vital Records data, Medicaid data and WIC databases. In the past, one of the problems Michigan faced in collecting data for the Block Grant performance measures and health status indicators was the need for utilizing data across different divisions and even departments to obtain the numerators and denominators for the measures. Consequently the sources of the data and assumptions employed varied from year to year. With the addition of the data warehouse, our MCH epidemiologist can develop standardized computer codes for the block grant measures so that they may be collected in the same manner regardless of changes in staff or reorganization within the department. The ability to save the computer codes will allow more consistent reporting of measures. The data warehouse also provides a rich resource for linkage and analysis of program data which are being used to evaluate the effect of MCH programs on MCH outcomes. In FY '04, responsibility for access, training and maintenance of data uploads was transferred from a contractor to the Department of Information Technology. During the past year, a major effort of the Data Warehouse has been to revise the models from various data sources to comply with HIPAA provisions and provide training to users on the the revisions.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

For the 2004 reporting year, the state's priorities remain unchanged from the 2001 needs assessment. Michigan's focus continues to be on improving birth outcomes, reducing racial disparities in health indicators and improving child health including children with special health care needs.

For 2004 (or the latest year for which data is available), Michigan met or exceeded targets for the following performance measures:
NPM #1 Newborn Screening
NPM #8 Birth Rate for Teenagers 15-17
NPM #10 Deaths to children caused by motor vehicle crashes
NPM #11 Breastfeeding
NPM #13 Percent of children without health insurance
NPM #16 Suicide Deaths among youth 15-19
SPM #04 Preterm Births

Other performance measures that showed improvement from the previous year but did not meet the target were:
NPM #9 Third grade children who have received protective sealants
NPM #15 VLBW Births
NPM #17 VLBW Deliveries at facilities for neonates and high risk deliveries
SPM #01 Infant Mortality
SPM #05 Unintended Pregnancy
SPM #08 CSHCS beneficiaries receiving dental care paid by CSHCS
SPM #09 Lead testing among Medicaid eligible children 0-6

Measures that did not show improvement and require further effort are:
NPM #7 Childhood Immunizations
NPM #12 Newborn Hearing Screening
NPM #14 Medicaid-eligible children received a service
NPM #18 Infants born to pregnant women receiving care in first trimester
SPM #02 Maternal Mortality Ratio
SPM #03 LWB among live births
SPM #06 Repeat live births to unwed mothers 15-19 years of age

National Performance Measures 2-6 are related to Children's Special Health Care Services. The only source of data for these performance measures is the SLAITS survey which is only conducted every other year. Data has not been updated since the original survey which indicated that Michigan's data for NPM #2-5 were above the national average for 2001 and slightly below the national average for NPM #6 (Percent of youth with special health care needs who received services necessary for transition to adult life).

Although the data for 2004 for SPM #07 (CSHCS Beneficiaries enrolled in SHP) indicates an improvement, the Specialized Health Plans were discontinued as of October 1, 2004.

The strategies and activities described in Section IV. C and D are planned in the context of state initiatives proposed by the Governor and the Department of Community Health and the state's budget picture. The Title V program is actively involved in the Great Start Initiative focusing on children 0-6 years of age. See Section III.A for further description of the Great Start Initiative. The Department of Community Health has developed a state health status report building on the Healthy People 2010 format entitled "Healthy Michigan 2010." Healthy Michigan 2010 profiles the state's demographic, socioeconomic and healthcare status and, like Healthy People 2010, includes a focus area for maternal and child health. Following that, the state Surgeon General issued "Prescription for a Healthier Michigan" which included a set of recommendations for improving the health of Michigan

citizens. The recommendations include unintended pregnancy, infant mortality and childhood lead poisoning. The Title V program is also implementing new infant mortality strategies, has developed, in cooperation with the Medicaid program, a waiver request to extend family planning services, is re-engineering the Maternal/Infant Support Services program and is implementing new legislation regarding childhood lead poisoning.

The CSHCS program is making significant strides in increasing its access to CSHCS pertinent data through the development of the MDCH Data Warehouse project. We are working very closely with department systems staff and staff of other MCH programs for the purpose of linking the available data to gather comprehensive data regarding our overlapping populations. The work between the various programs is expected to result in even more meaningful collaboration in assessing needs and providing services and resources in a more efficient manner for families and for the programs themselves. Collaboration has begun at a more detailed level than before with the Bureau of Epidemiology, Division for Vital Records and Health Statistics (Michigan Birth and Death registry), the Michigan Central Immunization Registry, the Childhood Lead Poisoning Prevention Program. The purpose of the collaboration is to gather and cross reference data to determine where Michigan is most and least successful in assisting families regarding multiple health care circumstances and needs. This process in turn will drive the decision making toward the greatest needs, and how best to address it.

B. STATE PRIORITIES

Establish a system to better identify, screen and refer for maternal depression: Postpartum depression (PPD) occurs anytime during the first year after delivery with an estimated prevalence of almost 12%. The onset of PPD usually takes place after baby blues and ranges from mild to severe depression. Postpartum psychosis is the extremely severe form in which the mother loses touch with reality and has thoughts of suicide/homicide. It affects about 1 in 1,000 women. PPD affects a woman's ability to function as a new mother and can impair the cognitive and language development of the newborn.

Increase the rate and duration of breast-feeding: The Healthy Michigan 2010 Goal for breastfeeding mirrors the national Healthy People 2010 Goal of increasing the breastfeeding initiation rate to 75% and the 6-month duration rate to 50%. While making progress, the Michigan breastfeeding rates are well short of the goal. According to the most recent Ross Laboratories survey (2002), the U.S. breastfeeding initiation rate in the hospital was 70.1% and the 6-month duration rate was 33.2%. College educated mothers exclusively breastfeed at a rate that is 50% higher than mothers without a college degree. White mothers exclusively breastfeed at a rate double that of black mothers. The survey reported Michigan figures as 65.5% initiation in hospital and 28.0% for 6-month duration. With the many reported benefits, increasing the breast-feeding initiation and duration rates in Michigan will have a positive impact on the health status of Michigan infants. The promotion and protection of breast-feeding among Michigan WIC eligible and black mothers is an even more important public health goal.

Reduce the percentage of unintended and teen pregnancies: Of the Michigan women experiencing unintended pregnancies in 2002, the largest percentage fell within the 20-25 year age group at 39%. Teenagers (ages 19 or younger) accounted for 20% of Michigan's unintended pregnancies. Among women who experienced an unintended pregnancy our PRAMS data shows that 68.4% were Medicaid recipients at some time during their pregnancy. This calls for renewed effort to address access and barriers to care issues for women in this population. Michigan has enjoyed a steady decline in teen pregnancy and birth rates across all subsets of the teen population for more than a decade. While Michigan has seen significant progress in this area, reducing the rate further remains a high priority as Michigan continues to have an alarming number of youth who experience the serious health, emotional and financial consequences of pregnancy, childbirth, and engagement in sexual activity and other risky behaviors. The teen pregnancy rate for Michigan is 56.4 per thousand (ages 15-19, 2003). In Michigan during 2003, 17.6% of teens who had previously given birth experienced a

repeat birth. This is a reduction from a high of 26.7% in 1992. Racial disparities continue with 22.6% of black teens under the age of 20 years experiencing a repeat unwed birth while 14.7% of white teens experienced a repeat unwed birth.

Reduce the percent of pre-term births and births with low birth weight with emphasis on the black population: The percentage of pre-term births to all races has remained relatively steady from 1999 (10.8) to 2003 (11.1). The percentage of births with low birth weight has also remained about the same. Both indicators continue to be 2 to 3 times more likely for black babies. Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Pre-term births are less affected by younger age in black women. Pre-term births are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births.

Establish a medical home and increase care coordination for children with special health care needs: Children with special health care needs (CSHCN) have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. More importantly, there is often times a lack of communication between providers and no focal location for great concern as medically fragile CSHCN are already at significant health risk because their medical conditions may fail to improve, or even deteriorate. Discussion is underway regarding the definition and criteria for determining medical practices as "medical homes" and how best to assist practices in achieving that designation. Michigan is considering ways and means to work with the concept of a medical home. Efforts are underway to implement and study a model for private practices to determine how to expand the medical home concept. Michigan has received training and technical assistance through the Federal Medical Home Learning Collaborative supported by MCHB. Initially Michigan was developing the medical home model through the CSHCS Special Health Care Plans (SHP). Unfortunately the SHP contracts have been terminated as of October 1, 2004. CSHCS does not have the resources to accommodate the federal requirements that have been newly applied to the SHPs (already standard for Medicaid Health Plans) or to administer the two separate models of the traditional CSHCS and SHPs. CSHCS has incorporated the assistance of the MI AAP and the on-going assistance of the Federal Medical Home Learning Collaborative in establishing medical homes for this population. CSHCS will apply the best of what was learned from the SHP model to the traditional FFS model as is feasible.

Increase the number of CSHCS enrolled youth who have appropriate adult health care providers: Increasing the number of CSHCS enrolled youth who have appropriate adult health care providers is a priority because there currently is a need for an adequate number of physicians who are able, willing and comfortable serving the ever-increasing adult population who have had many kinds of special health care needs since childhood. Historically, there has been less need for knowledgable adult health care providers for many special needs conditions because the children with those conditions often did not survive into adulthood. More of the children with complicated and life-endangering conditions are now surviving into adulthood than ever before. Adult providers need to be recruited, trained and supported in learning how to care for adults with these conditions.

Reduce the proportion of children and adolescents who are obese: No current baseline percentages exist regarding Michigan children and adolescents who are overweight, obese and/or lacking opportunities for physical activity. Baseline data will be gathered during 2005 so future comparisons and percentages can be determined. During 2005, professional associations, standard-setting organizations (i.e., M-QIC) and public agencies will develop and reach consensus on guidelines for the prevention and management of overweight in children in clinical settings. Guidelines for nutrition and physical activity will be widely disseminated to primary health care providers, educators and other school personnel and the public. WIC and other maternal and child health staff will work with staff in the Community Public Health Administration to develop and implement a plan to enhance breastfeeding among program participants and address healthy weight and feeding issues. Training for WIC and other maternal and child health program staff will be implemented as part of the plan. Efforts will also be focused in increasing the number of Michigan schools that make changes to

policies, programs and practices focused on making school environments more supportive of healthy eating and physical activity. Nutrition and physical activity content of the Michigan Model for School Health Education will be reviewed and revised as necessary to provide consistency with Michigan consensus guidelines for healthy eating and physical activity. Legislation has recently been introduced that would make nutrition education and physical activity mandatory in all Michigan schools.

Reduce incidence of teen suicide: In Michigan, suicide is the third leading cause of death for 15-19 year olds and the second leading cause of death for college age young people. Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics. An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years.

Increase the screening rate of low-income children for lead poisoning: Michigan residents are exposed to lead in their environment from sources such as lead-based paint, dust, soil, food, and water. The exposures are cumulative in children, especially those under six years of age, because they are more vulnerable to the toxic effects of lead and show greater effects upon the blood forming and central nervous systems. Children living in poverty are most at risk. According to the 2003 American Community Survey (U.S. Census Bureau), it was estimated that 144,760 children ages 0-5 resided in households with incomes below poverty. In 2004, lead testing was reported on 125,417 children below age 6. Of those children tested, 93,634 were Medicaid-eligible. Of the total children tested, 3,126 (2.5%) had levels greater than or equal to 10 micrograms per deciliter. Because of 1) the existence of significant numbers of old houses in Michigan, 2) the fact that the percentages of children living in poverty are increasing, and 3) there are medical and public health interventions that are available to prevent and lower blood lead levels in children identified with elevated lead levels, this is a public health priority in Michigan.

Reduce the racial disparity between black and white infant mortality and between Native American and white infant mortality: In 2003 the white rate was 6.7 and the black rate was 17.5 demonstrating a slight decrease in the disparity since 2002 due to declining a black rate and a rising white rate. The disparity has remained fairly consistent at a ratio of 2.6 since 1994. Ninety eight percent of the black infant deaths occur in eleven urban communities that are now being targeted for study and coalition building to improve health care systems to reduce the problem. Since 1997 the Native American rates have risen from 8.7 to 12.4 using three-year averages. Over the same period the white rates have increased from 5.9 to 6.7 using annual rates. Native American infant deaths are few in number and scattered across the state making targeted efforts difficult. Eight of the 12 recognized tribes in Michigan are part of the HRSA Healthy Start Project and have benefited by education and nursing services at the local reservations.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective			100	100	100
Annual Indicator			100.0	100.0	100.0
Numerator			194	196	183
Denominator			194	196	183
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2004, 128,456 newborns were screened, and 185 infants were diagnosed with one of the eleven disorders. Three contractual agreements were maintained for medical management of metabolic disorders, endocrine disorders and hemoglobinopathies. A new clinic for diagnosis and treatment of metaboloic disorders opened on October 1, 2004. The Children's Hospital of Michigan, Metabolic Clinic is staffed by three clinical biochemical geneticists, one clinical geneticist and one PhD biochemical geneticist. A Center of Excellence for the diagnosis and management of congenital adrenal hyperplasia was established at the University of Michigan on October 1, 2004. The screening panel was expanded to include citrullinemia/ASA and homocystinuria deficiency in October 1, 2004. A Newborn Screening Advisory Committee met four times, and a Birth Defects Advisory Committee met three times. The department also maintained agreements for the provision of genetic services at five center-based genetic clinics and 10 outreach sites where patients and their families received genetic evaluation and counseling services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Screened 128,456 newborns	**X**			
2. Diagnosed 185 infants with one of eleven disorders	**X**			
3. Contracted for medical management of metabolic disorders	**X**			
4. Screening panel expanded to include citrillinemia/ASA and homocystinuria				**X**
5. Contracted for genetic evaluation and counseling services	**X**			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Implementation of the 5-year state genetics plan continues. The plan addresses all stages of the lifecycle, including reproductive issues such as birth defects prevention, birth defects follow-up and linkage with the medical home, expansion and enhancement of newborn screening,

pediatric genetics, and adult genetics including integration of genomics with chronic disease programs. Improvements in NBS infrastructure continue to be made as part of a HRSA Genetics Implementation grant. An algorithm, to link NBS specimens to birth records, has been developed in order to identify unscreened infants. An online newborn screening training course has been developed, and quarterly update newsletters are sent to hospitals and midwives. Program staff collaborate with Children's Special Health Care Services to identify opportunities for facilitating the medical home concept, and participate in a work group on child health data integration that would allow provider access to NBS results through the Internet based childhood immunization registry. To facilitate and increase communication with consumers and the public, a genetics resource center continues to be enhanced. A toll-free telephone line has been acquired and a website, www.migeneticsconnection.org has been launched that will serve as a portal to genetics-related information for the state of Michigan. A targeted folic acid educational campaign was implemented

c. Plan for the Coming Year

The screening panel will be expanded to include the HRSA recommended panel which is expected to be an additional 29-30 disorders. A newborn screening nurse educator and a newborn screening nurse coordinator will be added to improve program infrastructure. A model medical home pediatric practice for coordinated management of newborns and children with metabolic disorders will be developed in conjunction with CSHCS and Spectrum Health in Grand Rapids, Michigan. Contractual agreements for regional genetic centers and outreach clinics will be continued. State program staff plan to participate in a HRSA-funded regional collaborative for genetics and newborn screening, should a successful proposal be submitted from the Midwest.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			61.3	61.3	64
Annual Indicator			61.3	61.3	61.3
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.3	61.3	61.3	61.3	61.3

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The National Survey of CSHCN reported 61.3% success resulting from the combination of results to two questions for Michigan as of 2001. This result is above the national average. Positive response to "Doctors usually or always made family feel like a partner." was 89.1%. Positive response to "Family was very satisfied with services received." was 63.9%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

The parent-directed staff of the Parent Participation Program (PPP) (including five parents of the children with special needs) remains in contact with families statewide, using the information that is obtained to proved consultation to the Michigan Title V programs regarding program and policy development. The PPP is an integral part of CSHCS Plan Division and is treated as a section within the division. All written materials intended for families, as well as CSHCS policy and procedure, are reviewed by this group for recommendation and revision as needed. Family participation is a constant regarding CSHCS policy and program development. Proposed policies, letters to families, procedural and other documents undergo review, comment, and recommendation by parent representatives as a regular course of events.

Review and comment of the federal MCH Block Grant application was also provided by PPP. Due in part to PPP there are also 333 volunteer Family Support coordinators within various communities in Michigan who provided over 1207 volunteer hours in 2004 and established 380 family matches for peer support. PPP continued to staff the Family phone line that assists families in accessing their providers, other families with similar circumstances, and assistance in obtaining information regarding the status of their child's CSHCS coverage. PPP provided scholarship for parents to attend conferences when the subject matter was germane to their child's specific diagnosis, medical care and treatment. PPP also provided in-service training from a family centered perspective for families, Pediatric Regional Centers, Medicaid HMOs, local health departments, and various agencies.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review CAHPS results to assess issues, needs, etc.				X
2. Develop, distribute, and analyze results of family satisfaction survey targeted to this issue.		X		
3. Incorporate requirement to address families as partners in decision making into Medical Home Model.				X
4. Administer another CAHPS.				X
5. Conduct youth and family discussion groups regarding transition.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

Michigan's Parent Participation Program (PPP) is an excellent resource for obtaining family input and determining problem areas in need of being addressed. As a pro-active process, PPP provides Parent Empowerment sessions to assist families in learning how to be most effective in communicating with their children's physicians and other caregivers. Based on the large number of calls that PPP receives per year from families, we are able to keep abreast of current and rising issues in the families of children with special needs "community". In addition, Michigan has consistently had a very high rating for the old NPM #14 regarding family participation in program and policy activities. NPM #02 does not appear to be a large problem in Michigan based upon the types of calls received by PPP. CSHCS continues to monitor client and family satisfaction through the types of calls received at PPP through the Family Phone Line.

c. Plan for the Coming Year

The Michigan CSHCS program will work collaboratively with the PPP to develop, use and analyze the results of a satisfaction survey intended to address the concern stated in NPM #02. In addition, Michigan will include features related to physicians partnering with families of children with special needs while developing the medical home model, and incorporate aspects of family centered care and family inclusion as partners in the decision making process as related to individual practices and the medical home model (see NPM #03).

PPP will continue to provide consultation to the Michigan Title V programs, as well as the existing services to families that include;
1. The Family Phone Line, a statewide Family Support Network that offers:
a. information,
b. family "matches" between families dealing with similar circumstances regarding the child with

special needs,
c. emotional support to parents, grandparents, siblings and other caregivers of children with special
needs.
2. A biennial conference for siblings of children with special needs;
3. Scholarships to enable parents to attend conferences related to the diagnosis, care, or medical
treatment of their children with special needs;
4. In-service training for families, Pediatric Regional Center, Medicaid HMOs, local health departments, and various agencies.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective			55.8	55.8	58
Annual Indicator			55.8	55.8	55.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.8	55.8	55.8	55.8	55.8

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The National Survey of CSHCN reported 55.8% success resulting from the combination of results to five questions, with ten sub-questions, for Michigan as of 2001. This result is above the national average. Positive response to "The child has a usual source of care." was 88.2%. Positive response to "The child had a personal doctor or nurse." was 89.7%. Positive response to "The child had no problems obtaining referrals when needed." was 82.7%. Positive response to "Effective care coordination was received when needed." was 48.9%. Positive response to "The child received family-centered care." was 70.3%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed. Partners have been brought into the process such as the Michigan AAP Chapter, and the Federal Medical Home Learning Collaborative.

In 2003, Michigan was still defining a medical home as enrolled with a commercial HMO or a CSHCS Special Health Plan. The result of that measurement was 33.2% had a medical home. Michigan is now taking a new approach regarding the definition of a medical home (see below) in conjunction with this new performance measure for 2004.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Develop new & comprehensive Medical Home Model in collaboration with Public Health entities.				**X**
2. Work closely with some practices to incorporate new or revised model.		**X**		
3. Finalize concensus definition in collaboration with the MI Chapter of the AAP.				**X**
4. Medical Home Model (MHM) Analyst to research and assess other MHMs and provide recommendations and assistance with implementing the MHM.				**X**

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

To develop consensus and support for the definition, an interest group of the Michigan Chapter of the AAP is working with the CSHCS program to carry out the work of the MHLC. The Michigan consensus definition will be critical to the process of developing future support for policy and reimbursement mechanisms, and the ability to expand the medical home concept across practices in the State.

c. Plan for the Coming Year

We are working toward the further development and expansion of the medical home concept. The Cherry Street Community Health Center, a long established and respected FQHC in Grand Rapids has incorporated the MHLC guidelines. We are partnering with the Cherry Street leadership in approaching the Michigan Primary Care Association to expand and spread the Medical Home Initiative throughout that network to take advantage of their coverage of underserved areas of the State.

To maximize efficiency, the CSHCS Program is joining a coordinated effort with the Metabolic Screening, the Hereditary Disorders (Genetics), and the Early Hearing detection and Intervention (EHDI) Programs to develop the Medical Home concept. Each program has requested the Office of Medical Affairs (OMA) to lead in the effort to see that all children with special health care needs will receive coordinated ongoing comprehensive care within a medical home. We will jointly develop a measure for this priority.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			66.5	66.5	50
Annual Indicator			66.5	66.5	66.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional

	2005	2006	2007	2008	2009
Annual Performance Objective	66.5	66.5	66.5	66.5	66.5

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

The National Survey of CSHCN reported 66.5% success resulting from the combination of results to five questions for Michigan as of 2001. This result is above the national average, however significantly different from the data Michigan routinely monitors as related to the CSHCS specific population. Positive response to "The child has public or private insurance at time of interview." was 96.0%. Positive response to "The child has no gaps in coverage during the year prior to the interview." was 91.5%. Positive response to "Insurance usually or always meets the child's needs." was 88.5%. Positive response to "Costs not covered by insurance are usually or always reasonable." was 75.3%. Positive response to "Insurance usually or always permits child to see needed providers." was 92.0%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

Michigan has been monitoring the status of private and public insurance for persons enrolled in the CSHCS program. We have no way of identifying other persons with special needs who are eligible but not on CSHCS, or those having special needs other than those that would be covered by Michigan CSHCS if enrollment occurred.

Of those with CSHCS coverage in 2004, 99.3% had coverage for at least one month in addition to CSHCS, i.e., Medicaid, MIChild (SCHIP), and/or private insurance as identified on the Medicaid Management Information System (MMIS).

In an attempt to assist families with access to more coverage Michigan sent a specific mailing, letter and application, to families with CSHCS coverage when it appears they may be eligible for the MIChild/Health Kids programs to invite them to apply.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to monitor.		X		
2. Maintain outreach efforts to families who may need assistance paying insurance premiums.		X		
3. Support local health depts.efforts proactively assisting families who might be eligible with application process		X		
4. Maintain mailing to applicants encouraging they also apply for MIChild.			X	
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

We continue to monitor the CSHCS population regarding their access to other insurance, either private or public. See Form #7 for a more detailed breakout of coverage. The mailing continues to occur for new applicants who appear to be eligible at the time of CSHCS application.

c. Plan for the Coming Year

We will continue to monitor the CSHCS population in the same manner as we have been monitoring for other insurance coverage. Given the current rate of success, Michigan CSHCS plans to continue with the current practices.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			75.7	75.7	79
Annual Indicator			75.7	75.7	75.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75.7	75.7	75.7	75.7	75.7

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

National Survey of CSHCN reported 75.7% success resulting based on a single question for Michigan as of 2001. This result is above the national average. Positive response to "Services are usually or always organized for easy use." was 75.7%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed. Michigan had a higher than average score for this factor. Michigan relies heavily upon the local health departments (LHD) to assist families in locating additional resources within their community. The CSHCS efforts to increase the success of this role has been to work much more collaboratively with the LHDs to this end.

Michigan acknowledges that organization of services within specific communities is the responsibility of the communities. We rely upon the LHDs to assist families in locating and accessing services within the local or nearby community. We will continue to work in a collaborative relationship with LHDs in Michigan including revision of the methodology by which the LHDs are reimbursed for their valuable services. Improvement in local CSHCS infrastructure is needed and local/state collaboration will be necessary to successfully accomplish this improvement. A work group will be developed to study the funding structures with the goal of having a new methodology.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to establish closer relations with the Local Health Departments.			X	
2. Continue to study funding structures to recommend further improvement from current structure.				X
3. Enlist the CSHCS Advisory Committee to monitor and recommend program revisions.				X
4. Finalize and distribute Transition Resource Manual to support LHDs in more efficiently helping families navigate and access their community-based service system.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

New performance measure for 2004. Since February of 2003, the CSHCS Division has worked to develop collaborative mechanisms with local health departments. CSHCS has established workgroups with various LHD representatives to reconsider many of the requirements or restrictions on the LHDs that have been in place for some time. This appears to be increasing communication and the generation of creative ideas. CSHCS also hired a Transition Analyst whose role it is to work with the LHDs in identifying what types of information and assistance they need regarding the transition services and resources that are available to clients as well as appropriate timing for approaching a family with recommendation of preparing for certain transitions which will include community resources. PPP also hired a parent as a Transition Consultant. These two positions are working as partners to improve assistance to families. In addition, PPP published a Family Guide about CSHCS as a resource that will assist families in contacting community and statewide services.

c. Plan for the Coming Year

Steps taken to ensure a statewide system of services that reflect the principles of comprehensive, community-base, coordinated, family-centered care include the reconsideration of the role of the Local Health Departments within the communities. Previous efforts have focused on centralizing activities, operations and communication with families and the medical community. Michigan is re-assessing that direction in such a way as to utilize the best of both approaches by considering what can and should be available centrally, locally or both. CSHCS will continue to reconvene various advisory groups, and ad hoc committees to determine current needs of families regarding special health care needs. It is believed that Michigan's greatest resource and strength for supporting communities including the coordination of health and other services within the communities is found in the Local Health Departments. The CSHCS Transition Analyst will continue to increase the LHDs resources and knowledge regarding transition needs and timing. The LHDs will assist families in when and how to access the needed services at the appropriate time so families will have some advance assistance regarding community resources.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			5.8	5.8	6
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

National Survey of CSHCN reported 5.3% success resulting from the combination of results to two questions and three sub-questions for Michigan as of 2001. This result is .5% below the national average, yet the study itself indicates these results do not meet the standard for reliability or precision. The relative standard error is greater than 30%. Positive response to "The child receives guidance and support in the transition to adulthood." was 18.5%. Positive response to "The child has received vocational or career training." was 24.9%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed. Since that time the goal has been revised to "All youth with special health care needs receive the services they need to make appropriate transitions to adult health care, work, and independence". The Michigan CSHCS focused on this factor as a higher priority than many of the others due to the low rating nationwide. CSHCS worked more closely with the local health departments (LHD) who are the community arm of CSHCS in order to discuss and empower them in assisting families in locating and accessing services that will assist clients in transitioning to adult life. We developed a survey of the LHDs to identify the types of transition information they feel they are lacking or would like additional support and information.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ID aging-out of CSHCS with outdated hemohilia codes to determine if eligiblie to be recoded for adult coverage.	X			
2. Local Health Departments work with aging-out population with MA to assist with MA managed care rules.		X		
3. Transition Analyst to increase the collection and development of resources the LHDs need.				X
4. Conduct youth and family discussion groups regarding transistion needs and experiences.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCS and Medicaid staff implemented Phase I and Phase II of a plan to assist people with both CSHCS and Medicaid, who are close to "aging out" of CSHCS (age 21) to prepare in advance for the Medicaid Health Plan selection process. This process requires persons with Medicaid to choose a Medicaid Health Plan (MHP), or secure an exception to the process, or be automatically enrolled in a MHP. CSHCS is working with the LHDs to prior-identify individuals or families early enough to educate them as to what to expect in the process. This includes identifying which MHP the person's providers participate with to be prepared to make the choice as soon as the enrollment information arrives to avoid being automatically enrolled with a different MHP, or to have started the exception to MHP enrollment process if applicable. The intent is to inform and assist with the transition into an MHP as an adult and to provide whatever assistance will be of use to the family and the MHP. As aged out members choose an MHP, the department identified the individual as a previous CSHCS enrollee so the MHP has advance notice that a person with exceptional and possible immediate needs is enrolling in the MHP. PPP/CSHCS also received a Champions For Progress Grant with which we are

conducting discussion groups with both youth and family groups regarding transition needs. This also expected to result in a CSHCS Youth Advisory Committee. PPP surveyed families regarding their knowledge and needs concerning transition.

c. Plan for the Coming Year

We plan to analyze the results of the above activities to determine the highest priorities for the next steps that would be most useful (to families and the department) to assist with transition into adulthood for future activities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	92	85	87
Annual Indicator	73.7	70.0	81.6	81.5	81.2
Numerator	147032	185408	166523	158336	152922
Denominator	199500	264680	204072	194277	188328
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	89	91	91	91	91

Notes - 2002

The data for 2002 is not available.

Notes - 2003

Neither actual or estimated immunization data is currently available for 2003. National Immunization Survey data is used and will become available later in the year.

Notes - 2004

2004 data will not be available from CDC until August.

a. Last Year's Accomplishments

The most recent data from the National Immunization Survey conducted by the Centers for Disease Control and Prevention (CDC) shows Michigan's immunization rate in 2003 to be 81.5% for 4+doses of DTaP, 3+doses of polio, 1+dose of MMR, 3+doses of Hib, and 3+doses of Hepatitis B (4:3:1:3:3) vaccines for 19 to 36 month old children. This is above the National average by 2%. The HP2010 objective calls for each vaccine series to be at or above 90%. In Michigan all vaccine series are above 90% with the exception of 4 doses of DTaP and 1 dose

of varicella.

The population based rates measured in the Michigan Childhood Immunization Registry (MCIR) as of January 1, 2005 is 59% for the 4:3:1:3:3 series and 57% when varicella vaccine (4:3:1:3:3:1) is added to the series. The MCIR continues to lead the way nationally, and has been recognized as such, in implementing a fully functional immunization registry which is available to both public and private providers across the state. Much work was done on the MCIR to integrate school and child care reporting utilizing data which exists in the MCIR as well as the technology of the web to report to local health departments and the State. A new recall/reminder system was created. In 2003, the system was rolled out to local health departments for use. This recall system was made available to private providers in 2004 and has shown great success in improving immunization rates where it is being utilized..

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained the Michigan Childhood Immunization Registry				X
2. Integrated school and childcare reporting into MCIR				X
3. Recall/reminder system made available to private providers				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In early 2005 MCIR functionality was added which allows schools and childcare centers to utilize data in the MCIR and submit reports through the MCIR system. Full functionality will be available and utilized for the school reporting year beginning in September of 2005. This functionality in the MCIR will streamline the reporting process as well as save time for physician offices, schools and child care centers, local health departments, and at the state health department.

Michigan is increasing the number of outreach activities to provider offices. Michigan plans to do 300 Assessment, Feedback, Incentive, and Exchange (AFIX) sessions in provider offices as compared to 128 last year. These AFIX visits provide physician offices with valuable information to help them improve their immunization levels.

The Division of Immunization has coordinated the formation of a Flu Advisory Board to assist the State in management of influenza activities around the state. Working in conjunction with the Flu Advisory Board is a group who is charged with developing a flu module to be used by the Immunization Nurse Educators and Peer Educators to promote the new flu recommendations for children and assisting physicians to integrate these recommendations into their practice.

Collaborate with the City of Detroit Immunization Program to assist them to increase immunization levels. The immunization levels in the City of Detroit continue to lag behind the

rest of the State. The National Immunization Survey shows the immunization completion rate for the City of Detroit to be 69.6% for the 4:3:1:3:3 series which is approximately 12% lower than the State as a whole. The Michigan Immunization Program will assist in the development and implementation of a strategic plan with targeted efforts to increase immunization levels.

c. Plan for the Coming Year

FY06 Plans include promoting and making available the Michigan Childhood Immunization Registry (MCIR) to every immunization provider in the state free of charge. Currently, 2525 provider offices are submitting data to the MCIR and over 40 million shot records have been entered into the system for approximately 28 million children. A web-based version of the MCIR has been developed which has made the MCIR much more accessible for all providers. We will continue to enroll and train schools and child care centers on the use of the MCIR SIRS module and utilize that system for the reporting process.

Additionally, the promotion of AFIX for vaccination rates obtained at provider sites (private and public) has been implemented to increase immunization coverage rates. Promoting immunization education for current immunization recommendations and standards of practice continues to be another priority toward increasing immunization rates. Numerous educational presentations (pediatric, family practice, adult, varicella, OB/GYN, influenza, etc.) are available to providers and clinic staff free of charge as another mode for increasing the immunization rates.

For 2006, monitoring will occur for the number of provider users enrolled in the MCIR. Immunization completion rates for children in MCIR will also be assessed and tracked. In addition, the number of AFIX assessments to private and public providers will be monitored. For providers who have repeat AFIX assessments, a change in immunization rates will be monitored for improvement. Evaluation strategies for FY 06 include:
1. Monitor number of provider users enrolled in the MCIR and immunization completion rates for children provided services.
2. Monitor the number of AFIX assessments and the change in immunization rates with repeat assessments among public and private providers.
3. Monitor the utilization of MCIR among childcare centers and schools statewide.
4. Monitor the number of educational presentations to providers and their staff. Evaluate the change in immunization knowledge, attitude and behavior following educational presentations to providers.
5. Continue to collaborate with the City of Detroit Immunization Program to implement the strategic plan to assist in the increase in immunization levels.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	23.1	22.4	21.7	18	18
Annual Indicator	22.0	20.4	18.4	18.1	17.8

Numerator	4607	4263	3847	3894	3813
Denominator	209108	209108	209108	214590	214590
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.8	17.6	17.4	17.4	17.2

a. Last Year's Accomplishments

During FY 04 Michigan had several programs in place striving to impact the rate of birth to teenagers in the 15-17 year old age bracket.

The Michigan Abstinence Program (MAP) provides youth ages 9-17 years of age with intensive education regarding the benefits of abstinence from sexual activity and related risky behaviors such as the use of alcohol, tobacco and other drugs. Parents/guardians receive education regarding the importance of communicating with youth about sex and developing close, connected relationships with youth in order to positively influence youth decision-making. During FY 04 twelve funded community agencies provided 16,701 youth with abstinence education. Of that number, 11,833 youth participated in at least 14 hours of intervention. Six-hundred and forty-one (641) parents/guardians participated in MAP parent education. Local coalitions, representative of the community, provide oversight and direction for the programs. These coalitions also develop and implement community awareness activities designed to help the local community understand the benefits of abstinence for youth. A statewide media campaign with public service announcements (PSAs) for television and radio along with print media targets youth and parents in separate PSAs. Extensive technical assistance is provided to funded MAP communities. MAP programming meets the definition of abstinence education as outlined in both Section 510 of Title V of the Social Security Act and the MDCH appropriation boilerplate.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided abstinence education to 16,701 youth		**X**		
2. Provided parent education to 641 parents		**X**		
3. Supported local coalitions through the Michigan Abstinence Program				**X**
4. Conducted statewide media campaign			**X**	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MAP continues in the current year with the original 12 community agencies funded. On June

30, 2005 one community agency will no longer be funded, leaving the total number of MAP agencies at eleven (11).

c. Plan for the Coming Year

Continue to fund eleven MAP projects through FY 07.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	33	35	37	39	41
Annual Indicator	32.5	33.2	33.0	33.4	33.4
Numerator	43992	43790	42516	41889	41889
Denominator	135361	132017	128835	125417	125417
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	33.6	33.6	33.8	33.8	34

Notes - 2003

Data source for 2003 is the Oral Health Validation Survey, May-July, 2003

Notes - 2004

2004 data is based on the 2003 Validation Survey. The survey will not be repeated until next year.

a. Last Year's Accomplishments

The Oral Health Coalition had its first meeting in December, 2003 to expand the focus on oral health. An MCH epidemiologist was hired to develop a statewide surveillance system to collect data and monitor progress on HP 2010 goals for Oral Health. The Michigan Child Dental Coverage Validation Survey (DCS) -- 2003 was conducted as a telephone survey to determine if estimates of the county-level rates extrapolated from the statewide databases were approximately equivalent to those calculated from the survey for sealant placement on third grade children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Convened Oral Health Coalition				X
2. Hired epidemiologist for oral health to develop a statewide surveillance system				X
3. Hired Oral Health Coordinator				X
4. Conducted MI Child Dental Coverage Validation Survey to better determine sealant placement rates on 3rd grade children				X
5. Began development of the Oral Health State Plan which addresses the need for school or community based/linked sealant programs				X
6. Continued the Healthy Kids Dental Program to increase the capacity for oral health services for the low-income and uninsured	X	X		
7.				
8.				
9.				
10.				

b. Current Activities

Michigan hired a full-time Oral Health Coordinator in September 2004. The MCH epidemiologist completed the State Burden Document for Oral Disease and developed a surveillance system to collect data and monitor progress on HP 2010 goals for Oral Health. The Oral Health State Plan was completed by the Oral Health Coalition and presented to the MDCH Bureau Advisory Committee for adoption. The Oral Health State Plan addresses the need to develop school or community based/linked sealant programs. A review is being conducted of the funding from the MCH Block that is now distributed to two local health departments for a total of $110,400. The review is focusing on the redistribution of funding from the current structure of MCH Block Grant dollars to only two local health departments for preventive and restorative services into population-based statewide sealant programs that would have a greater total population impact. Michigan has continued its program to increase capacity for oral health services in the low income, dentally uninsured through the Healthy Kids Dental Program available in 37 counties.

c. Plan for the Coming Year

To address the need for population-based primary data collection rather than community based sealant placement or statistical estimates, the Basic Screening Survey (BSS) will begin in Fall, 2005. The BSS, using a statistical model, will survey 2,500 -- 3,500 children from 65-70 schools for sealant placement and caries experience. Encourage the redirection of MCH Block Grant dollars to establishing Community or school-based/linked sealant programs throughout the state to increase prevention of oral disease. Hire a part-time dental health consultant to coordinate the Sealant Program, educate communities on water fluoridation, and provide early Headstart and WIC intervention for the prevention of dental disease. Continue to work with the Oral Health Coalition to implement strategies for prevention of oral disease. Resume efforts to increase capacity for oral health services in the low income, dentally uninsured through the Healthy Kids Dental Program.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual					

Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.7	4.6	4.4	3.5	4.1
Annual Indicator	4.7	3.5	3.7	4.6	3.1
Numerator	102	75	79	96	65
Denominator	2164198	2164198	2164198	2098595	2098595
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.1	4	4	3.9	3.9

Notes - 2003

The annual performance objectives were adjusted for the following years (2004-2008) based on the data reported for the prior years (including preliminary data for 2003).

Notes - 2004

Data for 2004 are based on imcomplete death files at this time

a. Last Year's Accomplishments

MDCH continues to lead a statewide program for child passenger safety (CPS) public education including information on best practice/benefits of proper restraint use, MI law, & the dangers of airbags to unrestrained occupants & children. Programs focus on the needs of at-risk populations. MDCH conducts the CPS Technical Certification Course to certify individuals as CPS technicians (CPST). CPST conduct public events to provide CPS education on restraint correct use/installation. Michigan has 800 CPST and 35 CPS instructors. MDCH maintains a statewide listing of fitting stations that provide a place/time where parents can have a car seat inspected. MDCH continued work toward its three-year CPS strategic plan that includes recommendations in: Law Enforcement, Legislation, Education, Health Care & Family Service Providers, & Funding. MDCH received a grant from CDC to develop community interventions to reduce motor vehicle related injuries to children. MDCH has begun to develop & implement plans to increase the correct use of appropriate child restraint systems, with an emphasis on booster seats among low use groups. A statewide CPS coalition was formed to assist MDCH with the program. The second component of the CDC project is research. The University of Michigan Transportation Research Institute (UMTRI) was contracted to gather baseline booster seat use data. UMTRI conducted a statewide booster seat observation study & a statewide phone survey of parents. These scientific studies were the first in the country & will provide much-needed guidance to states in developing interventions. UMTRI has produced technical reports of the findings. MDCH began work on a hospital discharge policy program for infants. MDCH staff work directly with hospitals that have OB units to establish a hospital discharge policy for newborns & to provide CPS education to hospital staff. Free car seats are provided to hospitals that establish a policy & to hospital staff who complete the CPS certification course. MDCH conducted 2 courses for hospital staff.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. Conduct CPS Technical Certification courses				X
2. Conducted CPS education on restraint correct use/installation		X		
3. Implemented plans to increase correct use of appropriate child restraint systems with emphasis on booster seats		X		
4. Contracted with Michigan Transportation Research Institute to gather baseline data on booster seat use				X
5. Worked with hospitals to develop hospital discharge policy for newborns and provided free car seats				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY 05, MDCH initiated 2 contracts to conduct booster seat interventions with DeVos Children's Hospital & Branch-Hillsdale-St. Joseph Community Health Agency. Plans will include media campaigns, booster seat materials/public education, & permanent fitting station/free booster seats. MDCH continues hospital discharge policy work. Free child restraints are provided to hospitals that establish a policy & to staff who complete the CPS certification course. MDCH will conduct 2 courses for hospital staff. Car seat inspections will follow each course. Coalitions/chapters of the MDCH MI SAFE KIDS Program conduct CPS events in the state. Car seats are given to families that don't have a seat or have an unsafe seat. MDCH staff work closely with the State Police to develop CPS materials (brochures, posters, videos). A statewide CPS assessment was conducted to develop a new strategic plan for Michigan. A panel of experts evaluated CPS programs. MDCH will focus future efforts on recommendations of the report.

c. Plan for the Coming Year

MDCH will continue working toward reducing motor vehicle related injuries/deaths to children by increasing booster seat use, providing education to hospital staff, conducting CPS Courses & implementing recommendations of the Michigan Strategic Plan.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	60	62	69.4	69.9	70.5
Annual Indicator	63.1	68.8	72.3	75.4	78.5

Numerator	85846	91674	93693	98660	100692
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	71	71.6	72.2	72.8	73

Notes - 2002

No data is available for 2001 and 2002.

Notes - 2003

For the 2000 calculation, the numerator was from PRAMS and thus the percent changed by using as the denominator the total number of live births (higher than PRAMS estimate). For 2001 calculation, the PRAMS estimated percent was considered and the numerator was calculated based on the number of total live births reported.

Notes - 2004

The data source for breastfeeding is PRAMS. The last weighted data available is from 2002. Based on the change in percentages from 2000 to 2002, we calculated the estimated numbers for the last two years (2003, 2004). We will update this information as soon as we receive the 2003 PRAMS weighted data from CDC.

a. Last Year's Accomplishments

Accomplishments in promoting breastfeeding at hospital discharge through the WIC Program included the Mother-to-Mother Program --Breastfeeding Initiative. This program has been active for 11 years. It is a joint project of the MDCH WIC Program and Michigan State University Extension (MSUE). The program involves hiring and training paraprofessional peer counselors to work with WIC eligible mothers before and after delivery, in the WIC clinic, the hospital and in homes. Contacts include home visits, support groups for breastfeeding moms and telephone consultation. Peer counselors were employed in 22 counties and the City of Detroit. Supervision of the program is provided by Michigan State University Extension (MSUE); training and monitoring is provided by lactation consultants. In the past fiscal year ninety-five (95) percent of Mothers enrolled in the Mother-to-Mother Program initiated breastfeeding.

The WIC Division received one of nine competitive USDA Loving Support Grants. Implementation of the "Building a Breastfeeding Friendly Community" was initiated with national trainers from Best Start, Incorporated in January 2003. This Social Marketing campaign continued through FY ‘04 under the leadership of the Bay Area Breastfeeding Coalition (BABFC) and the grant project manager. The Coalition continued to train staff in local physician offices and began working with the Bay County Intermediate School District to develop breastfeeding education and support to pregnant and breastfeeding students. They also coordinated an outreach campaign that included billboard advertising and two Loving Support Rock and Rest tents for families attending the 4th of July Riverfront Festival (2004). Coalition leaders formalized breastfeeding worksite support materials which were incorporated into the local Chamber of Commerce Family Friendly Initiative Notebook (provided to all Chamber member businesses).

Another accomplishment was the Breastfeeding Basics Training Program. The WIC Division sponsors a two-day training four times each year for local agency WIC clerical and professional staff, local agency Maternal and Infant Support staff, breastfeeding peer counselors, Head Start, MSUE and hospital/physician office staff. The training provides an introduction to

breastfeeding and emphasizes support for breastfeeding women. Over 120 people participated in this training in 2004. To date, over 1200 local level people have been trained.

Michigan WIC also provides an annual one-day training for New Breastfeeding Coordinators. Approximately eight local agency WIC staff attended this training in Spring 2004.

A breastfeeding track at the 2004 Michigan WIC Conference included three breastfeeding training sessions for local agency staff.

The MDCH WIC Program also provided Pharmacist consultation to local agency WIC and MSUE staff concerning medications and breastmilk.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted Mother-to-Mother Program Breastfeeding Initiative		X		
2. Implemented "Building a Breastfeeding Friendly Community" initiative				X
3. Conducted Breastfeeding Basics Training program				X
4. Provided one-day training for new Breastfeeding coordinators				X
5. Provided pharmacist consultation to local WIC agency and MSU Extension staff				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In fiscal year '04 - '05, the WIC Division has continued to offer Breastfeeding Basics and Breastfeeding Coordinator training. Along with these, WIC Conference 2005 offered three new breastfeeding training sessions attended by more than 300 local agency staff.

The Mother-to-Mother Program --Breastfeeding Initiative has grown to provide services in 2 more counties bringing the total to 24 counties with peer counseling. State and local WIC and MSUE staff attended the 2nd of a two-part USDA/Loving Support training for the Midwest Region. This was built on a "train the trainer" model to support and enhance peer counseling training at the local agency level. As a result of this, the BFI Team is working on refining the training for our program's peer counselors. The WIC Division sponsored a leadership training, "BFI Team Building Workshop" for the local agency and state BFI management staff to strengthen local peer counselor programming.

Earlier this year, the WIC Division reached out to the Chronic Disease Division of MDCH. This collaboration is integrating breastfeeding messages into program areas such as diabetes, cancer, cardiovascular disease, physical activity and healthy weight.

Michigan Breastfeeding Awareness Month (August) will again be celebrated with a proclamation from the Governor, development and distribution of breastfeeding promotion materials (by state WIC) for use by the local WIC and MSUE agencies and activities such as breastfeeding walks, billboards, and rock and rest tents at local festivals.

The WIC Division continues to participate and provide leadership in a multi-state Nutrition Education on the Internet Project. Michigan WIC and the local Agency Breastfeeding Workgroup took the lead in developing the Breastfeeding Module for use by WIC moms. That module is now fully tested and is up and running. Feedback and support from other MWR states has been good.

The USDA/Loving Support Grant efforts to Build a Breastfeeding Friendly Community have continued beyond the official life of the grant funding. The Bay Area Breastfeeding Coalition is using materials purchased and/or developed through the grant to continue to educate physician office staff, local employers, daycare providers and the Intermediate School District. Cooperation continues between Bay Regional Medical Center, Bay county WIC and MSU Extension to provide breastfeeding education and peer counseling services to breastfeeding moms.

c. Plan for the Coming Year

While WIC supports and promotes breastfeeding, there remain many challenges to increasing initiation and duration rates. Resources are limited, local hospital policies often run contrary to supporting breastfeeding, employers are reluctant to provide time and appropriate private space for breastfeeding moms to pump breastmilk, federal regulations and state policies prompt postpartum women on public assistance to return to work early and without regard for breastfeeding needs such as an appropriate breastpump or time and space for expressing milk, and both Medicaid and it's contracted providers breastpump policies are often inconsistent in terms of providing pumps to mothers whose infants are either in the NICU or are discharged from the NICU still unable to nurse at the breast. The expansion of peer counseling services is limited by funding. All of these factors negatively impact breastfeeding initiation and duration rates.

Plans for FY '06 include: the addition of one more county to the Mother-to-Mother Program; continued training for local agency staff; joint training and conference calls for local agency WIC and MSUE staff involved in the Breastfeeding Initiative; focusing on social marketing methods to reach African American women; strengthening and improving breastfeeding workgroups, coalitions and networks; and promoting breastfeeding friendly worksites through education of employers and employees about breastfeeding worksite support.

The WIC Division has identified all the DCH programs that have a dstake in breastfeeding promotion, protection and support. As noted previously, we are already actively working with programs in the Chronic Disease Division of MDCH. WIC plans to gradually initiate collaborative planning and programming with each of the identified DCH programs.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	65	90	95	100	100

Objective					
Annual Indicator	73.1	80.7	92.6	90.6	90.2
Numerator	97853	106633	119094	116135	123035
Denominator	133815	132152	128624	128126	136436
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

In March of 2004, Michigan's last birthing hospital announced the implementation of their universal newborn hearing screening program. With the addition of this last hospital, Michigan EHDI has achieved 100% birthing hospital voluntary participation in universal newborn hearing screening. Roughly, 6,900 more infants received a hearing screen in 2004 compared to 2003. Pass and referral rates have remained fairly stable at roughly 97% pass and 3% referred. The average age of identification has continued to decrease from 3.9 months in 2003 to 2.4 months in 2004. Of the infants identified with hearing loss, all were referred to Part C services. Obtaining documentation of early intervention services continues to be problematic due to FERPA (Family Education Rights and Privacy Act) but for those cases that are reported, the average age of enrollment in early intervention continues to decrease from 5.3 months in 2003 to 5.1 months in 2004.

(run 5/19/05) 2003 2004
Hospitals Participating 98/99 = 99% 99/99 = 100%
Births (per Metabolic) 128,126 136,436
Screened 116,135 = 90.64% 123,035 = 90.18%
Passed 112,794= 97.12% 118,376 = 96.46%
Failed Screen 3,341 = 2.88% 4,350 = 3.54%
Hearing Loss Reported 149 avg age 3.9m 194avg age 2.4m
Early Intervention Reported 43avg age 5.3m 48avg age 5.1m

EHDI continues to provide resources and consultation to hospitals, increase public awareness through exhibiting and presenting, promote county collaborations through funding EHDI county brochure development, provide training consortiums and educational meetings. EHDI continues to maintain providers lists for hospital, rescreen, diagnostic, and early intervention sites. Physician education and family support continues as a priority for EHDI staff time and resources.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Achieved 100% participation of Birthing hospitals				**X**
2. Screened 116,135 infants	**X**			
3. Referred infants identified with hearing loss to Part C services		**X**		
4. Provided training consortiums and educational meetings				**X**
5. Provided family support		**X**		

6.				
7.				
8.				
9.				
10.				

b. Current Activities

EHDI is continuing to develop and implement various stages of database development. Database development includes building a comprehensive follow-up system, linking with other data systems, and researching provider Web base access options. EHDI has implemented and received referrals for a new family support program called "Guide- By-Your-Side". This program links families with newly identified infants with hearing loss to other hearing loss families in order to provide family support through the initial stages of diagnosis to intervention. The EHDI program is making hospitals site visits to provide consultation and training.

c. Plan for the Coming Year

EHDI will continue with the database development to ensure tracking and surveillance of infants through screening, diagnostic, and intervention services. The program will continue providing hospitals with quarterly reports on screening efforts. EHDI materials will continue to be distributed for family and provider use. EHDI staff will make efforts to work closer with midwives to ensure initial newborn hearing screening. The EHDI program will hold advisory meetings and obtain provider/family input into program operations and activities.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	6	4.6	3.6	6.8	6.7
Annual Indicator	6.7	8.1	6.9	5.8	5.8
Numerator	173916	196000	175117	147257	147257
Denominator	2595767	2427000	2541611	2538920	2538920
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.6	5.6	5.4	5.4	5.4

Notes - 2002

Data for 2002 is not available

Notes - 2003

Michigan utilizes estimates of uninsured data developed by EBRI based on the Current Population Survey of March 2003. An annual update will be completed later in the year. The annual performance objectives for 2003 and for the follwing years were changed based on the data reported for the prior years (1999-2002).

a. Last Year's Accomplishments

Between 1999 and 2002, the number of children dependent on public health insurance rose sharply from a combined total of Medicaid and MIChild enrollments in 1999 of 589,927 to a total of 782,452 enrollments for the two programs in 2002. The number of Michigan children who depend on Medicaid and MIChild increased by nearly one-third, primarily due to sustained community outreach for the MIChild Program, which identified and enrolled many Medicaid-eligible children. So despite significant cuts in health programs, Michigan has made important efforts to provide coverage to uninsured children. In 2004, seven percent of the pediatric population was uninsured compared to twelve percent for the nation. In 2003, nearly 750,000 qualified for Medicaid, with children and youth ages one to eighteen years eligible in families with incomes below 150% of poverty and infants in families with incomes below 185% of poverty. The dual enrollment procedure utilized to bring children into the Medicaid and MIChild programs continues, and although funding for outreach to local health departments has been cut due to budget shortfalls, between 8,000-10,000 children are enrolled per month with between 2,000-5,000 enrolled in MIChild and the remainder enrolled in Healthy Kids (Medicaid). The use of alternate sites for enrollment and continuing collaboration with other human services agencies supports the outreach to families with uninsured children. Families completing the dual enrollment are also able to self-report income, rather than being required to provide pay stubs or other proof of income before applications can be completed. Program enrollments and re-enrollments have remained steady during 2004, with MIChild enrollments of approximately 16,000 in any given month during the fiscal year, and slightly more than double the number of children enrolled in Healthy Kids.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased Medicaid and MiChild enrollment due to sustained community outreach for the MIChild program				X
2. Continued dual enrollment procedure to bring children into the Medicaid and MIChild programs				X
3. Use of alternative sites for enrollment and continued collaboration with other human service agencies for outreach to families with uninsured children				X
4. Planned for the newly funded NFP programs to identify and assist families who will need coverage for their children with enrollment				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

While outreach funds to local health departments were cut in early 2003, collaborative efforts including working with the Governor's Children's Action Network have increased enrollments in

publicly-funded programs and provided outreach to uninsured families. The development of Family Resource Centers in schools not meeting Adequate Yearly Progress will also serve as enrollment sites for children from families that are uninsured or underinsured. Newly funded Nurse Family Partnership programs in Detroit, Pontiac and Grand Rapids and an additional team in Berrien County will also identify families who will need coverage for their children, and these programs assist with enrollments in publicly-funded programs.

c. Plan for the Coming Year

Since the elimination of outreach funding to local health departments, the department has sought other community-based partners to assist in the outreach efforts to assure that children currently uninsured or underinsured obtain coverage for health care. Links with interagency programs such as WIC, MSS/ISS and Early On are already established, as are networks with Head Start, the Children's Action Network, schools and employers. Dual program enrollment will continue, and additional partners will be identified that are able to assist with outreach and/or direct enrollment on site. Collaboration will be expanded with day care centers, emergency food and shelter programs and a number of school programs to assure that families are aware of the MIChild and Healthy Kids programs. Assistance for on-site enrollment will also be encouraged whenever possible. The greatly expanded number of school-based health centers will also be a source of outreach efforts since outreach will be important for school-age children and adolescents, groups that are currently less reflected in the MIChild and Medicaid programs. Enrollment efforts will also be focused on underrepresented groups and subgroups having high rates of uninsured individuals.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	80	88.3	88.7	89.1	84.2
Annual Indicator	87.9	80.7	83.2	82.5	80.2
Numerator	709508	707856	707036	739523	792549
Denominator	807491	877338	849639	896104	988147
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	87.8	89.7	91.5	92

Notes - 2003

The annual performance objectives for the following years (2004-2008)were re-calculated based on the data reported for the prior years (1999-2002).

a. Last Year's Accomplishments

Since May 1998, 119,088 children have received health insurance coverage and access to health services through the MIChild Program, while an additional 263,048 children who parents completed the dual application for Healthy Kids (Medicaid) have been transferred and enrolled in the Healthy Kids Program. MIChild and the dual enrollment process continues to serve as a significant source of outreach for the Medicaid program. During the period between January and March of 2004, nearly 10,000 applications were forwarded to the Medicaid program by the MIChild program. Since the beginning of the program in 1998, approximately forty-six percent of the total enrollments are MIChild eligible, with the remainder enrolled in Medicaid. Outreach activity has been strong with a range of between 14,00 and 18,000 calls to the MIChild program each month throughout 2004. This trend continues into 2005, with slightly lower volumes of inquires (12,000 to 14,000) each quarter. 36,400 applications were processed between February and April of 2005. The sources of information about MIChild and Medicaid Healthy Kids are varied, but the majority of referrals come from friends and family (33%), human services agencies (20%), physicians (12.7%) and the Internet and mass media each at approximately 8%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued dual enrollment process for Medicaid and MIChild				X
2. Encouraged local integration of outreach and enrollment activities via continued collaboration with other agencies				X
3. Began sharing information about covered children so direct outreach can be more successful				X
4. Monitored data regarding use of Medicaid service by eligible clients				X
5. New initiatives (NFP, HRSA system of care grant, “Failing Schools Project”, C.A.N.) will include a focus on assisting young children in accessing services				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The dual application process for Medicaid and MIChild continues, with the majority of children eligible for the Healthy Kids program and approximately 1/3 eligible for MIChild. With the elimination of outreach funding to local health departments in 2003 due to a significant state of Michigan budget deficit, it was anticipated that this measure would be affected, but requests for applications have remained high, with referrals from a wide variety of sources. Several new initiatives have begun during the past year focused on young children and assisting them in accessing services. Several sites have been funded for Nurse Family Partnership programs, the HRSA system of care grant which includes medical home and sources of health care is in continuing development, and the "Failing Schools" project initiated by the Children's Action Network, based in the Office of Governor Jennifer M. Granholm, which provides assistance with Medicaid enrollment and other services, are all focused on increasing access to care for young children.

c. Plan for the Coming Year

A third year of funding has been requested for the implementation of the HRSA system of care, to support pilot activity to test the recommendations developed by the Steering Committee and the workgroups addressing data trends, current program efforts that would contribute to the implementation, gaps and needs that would affect successful implementation. The dual application process for MIChild and Medicaid will continue. Collaboration with other human services agencies will continue to assure the integration of outreach and enrollment activities. Work will continue with a variety of agencies to maximize outreach activities and the maximization of public and private insurances. Enrollment and service levels for eligible clients will also be monitored. In addition, the Children's Action Network is expected to add at least 20 more schools that will implement in-school activities to increase access to services for children. Medicaid and the Division of Family and Community Health have begun to share information about children covered under fee-for-service so direct outreach to this population can be increasingly successful.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4
Annual Indicator	1.6	1.7	1.6	1.7	1.6
Numerator	2133	2222	2103	2235	2111
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

a. Last Year's Accomplishments

Provisional data for 2004, 1.6% very low birth weight infants, reveals no change in this indicator. Using final 2003 data 3.6% of black live births were VLBW, while only 1.3% of white births were VLBW. This phenomenon is generally caused by preterm birth, which is much more common in African American births than other races. Intervening to prevent preterm birth has proved problematic despite many resources available for prenatal support.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Continued evaluating statewide fetal death data				X
2. Continued reviewing fetal deaths thru local FIMR teams				X
3. Implemented pilot preconception project in Kalamazoo County	X			
4. Began strategic planning to determine best practice strategies and how to redesign women's health services to include pregnancy planning and pre-pregnancy risk reduction				X
5. Planning to target communities with large black infant mortality rates for funding to support coalition building and analysis of service gaps				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Using a conceptual framework that suggests preconception care is the best strategy to prolong pregnancies to term, a pilot preconception project is now underway in Kalamazoo County to assess and manage interconception risks after the loss of an infant. A collaboration between the program and local hospitals allows for identification of women with early infant loss, and provides a grief specialist and nurse to provide care. Strategic planning is underway to determine the best practice strategies in this area and how programmatically this objective can be accomplished, namely to consider how to redesign women's health services to include pregnancy planning and prepregnancy risk reduction.

c. Plan for the Coming Year

Eleven communities with large black infant mortality rates are being targeted for funding to support coalition building and analysis of local gaps in service. Activities to improve the length of pregnancies and improve the health of the mother hold some promise for reducing the incidence of very low birth weight particularly among African American families.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	9	9	8.7	8.7	8.4
Annual Indicator	6.9	8.8	8.0	6.7	8.1
Numerator	50	63	58	49	59
Denominator	719867	719867	723088	728381	728381
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.1	8.1	8.1	8	8

a. Last Year's Accomplishments

A grassroots movement in Michigan, the Yellow Ribbon Campaign worked with young people in schools and communities to assist them in reaching out to an adult when they are in need of help. The campaign goes into schools and talks to young people and provides a "card" that they present to an adult as a signal that the young person needs to have a "conversation." The Michigan Model for Comprehensive School Health Education(r) is implemented in over 90% of Michigan's public schools and more than 200 private and charter schools. The Curriculum promotes life skills for children, K-12, in areas such as problem solving/decision making, resolving conflict, anger management, healthy lifestyles, listening skills, and feelings. The elementary section of the curriculum was revised after a series of focus groups.

The Michigan Suicide Prevention Coalition was initiated through the Michigan Association of Suicidology to develop a plan for addressing suicide in the state. The Coalition includes public and private organizations and agencies, foundations, individuals involved in suicide prevention, survivors (those who have lost a loved one to suicide), and professionals from around the state.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Participated in Yellow Ribbon Campaign		**X**		
2. Continued implementation of Michigan Model for Comprehensive School Health			**X**	
3. Revised elementary section of Michigan Model				**X**
4. Initiated Michigan Suicide Prevention Coalition				**X**
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Michigan Suicide Prevention Coalition (MiSPC) has developed a plan with the primary goals of increasing awareness across the state, developing and implementing best clinical and prevention practices, and advancing and disseminating knowledge about suicide and effective methods for prevention. The Coalition is now working on acceptance of the plan by key state officials.

Implementation of the Michigan Model is ongoing.

c. Plan for the Coming Year

Continue to secure support for the Suicide Prevention Plan.

Update/revise the plan as knowledge is advanced and best practices emerge.

Establish a Suicide Prevention Advisory Council.

Initiate development of a suicide prevention program within the Department.

Begin to establish local or regional suicide prevention coalitions.

Develop a comprehensive plan to implement a state-wide campaign promoting awareness that suicide is a preventable public health problem that reaches all citizens in Michigan.

Expand participation in symposiums held within the state on suicide prevention inpartnership with the Michigan Association of Suicidology, the Michigan Chapter of the Suicide Prevention Action Network and other public and private entities.

Educate officials on the impact that suicide, mental illnesses and substance abuse have on other policy areas such as health care, law enforcement and education.

Identify and distribute guidelines for suicide risk screening to primary care settings, emergency departments, mental health and substance abuse settings, senior programs and the corrections system.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85	85	85.2	88	88
Annual Indicator	88.0	86.5	87.0	84.8	87.4
Numerator	1856	1921	1829	1896	1846
Denominator	2109	2222	2103	2235	2111
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.2	88.2	88.4	88.4	88.6

a. Last Year's Accomplishments

Provisional data for 2004 on this parameter shows that 87.4% of low birth weight infants delivered at high-risk facilities. The close proximity to the performance objective of 88% suggests that the system of referral of high-risk pregnancies and neonates is generally working. The department MCH epidemiologist has determined that there may be a beginning rise in

perinatal deaths associated with delivery in Level 1 or 2 hospitals. Eleven communities across the state with racial disparities in infant mortality have some significant percentages of very low and moderate low birth weight infants born in hospitals without a NICU. The number of NICU beds is greater in some counties with lower numbers of high-risk births.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored data of low birth weight infants delivered at high-risk facilities to assure system of referral is working				X
2. Developed hospital survey to capture information about the level of service delivery, staff preparation, referral patterns, etc				X
3. FIMR program continues to share information about access to appropriate health system services				X
4. Determined communities with racial disparities in infant mortality have significant percentages of VLBW infants born in hospitals without a NICU				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

A survey of all hospitals that deliver babies was mailed recently. Returns are expected before the end of the fiscal year. The survey will capture information about the level of service delivery, preparation of staff, referral patterns, etc. and help inform the department about the perinatal system across the state.

c. Plan for the Coming Year

The data analysis will be done on the perinatal service system and information used to inform the department about changes needed to improve this indicator. The department will provide a staff liaison to the Wayne State University study of fetal death to help in collaboration of findings and data sharing. The FIMR program will continue to share information about access to appropriate health system services.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	85	85.7	85.9	85.9	85.9
Annual Indicator	80.4	82.9	83.9	84.1	82.7
Numerator	109346	110501	108653	110019	106116
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86.6	87.8	89	90.3	90.3

Notes - 2003

The annual performance objectives for the following years were changed/adjusted based on the data reported for the prior years (1999-2003).

a. Last Year's Accomplishments

The provisional 2004 data on this indicator shows another decline to 82.7% of mothers who received early prenatal care. Despite emphasis on creating new pathways to care through early referral from WIC, there continue to be a significant proportion of women who refuse or are unable to receive care in the first trimester. A group of key stakeholders met regularly over 2004 to redesign Medicaid support services for pregnant women. Emphasis is being placed on early entry and early risk assessment. Services will then be tailored to the client needs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Created referral pathway through WIC				**X**
2. Initiated redesign project for MSS/ISS with emphasis placed on early entry and early risk assessment tailored to the clients needs				**X**
3. The MSS/ISS redesign includes plans to pilot projects to test the feasibility of tools and process				**X**
4. The four Nurse Family Partnership projects have been enrolling clients for most of 2004 and offer early intervention for first time pregnancies	**X**			
5. Plans to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practices for improving early entry to prenatal care				**X**
6. Plans for the department to look at ways to study how much substance abuse occurs in childbearing age women and how inadequate contraception affects the timing of entry to care and ways to affect Medicaid and health plan policies to reward early entr				**X**
7.				
8.				
9.				
10.				

b. Current Activities

The redesign for prenatal support services is ongoing as the start date for the initial rollout

comes in the fall of 2005. Pilot projects in two counties are currently testing the feasibility of tools and process. The whole program will be implemented in stages. Cultural competence, an important consideration for readiness of women to seek early prenatal care, is a specific criterion for determining appropriate providers. The four Nurse Family Partnership projects have been enrolling clients for most of 2004 and offer early intervention for first time pregnancies.

c. Plan for the Coming Year

The plan for 2006 is to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practice for improving early entry to prenatal care. The department will also look at ways to study how much substance abuse in childbearing age women and how inadequate contraception affects the timing of entry to care. Additional influence is needed to affect Medicaid and health plan policies to reward early entry to care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Infant mortality rate of live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		7.5	7.4	8.1	8
Annual Indicator	8.2	8.0	8.1	8.5	7.6
Numerator	1112	1066	1054	1112	969
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.9	7.8	7.7	7.6	7.6

Notes - 2003

There is an increase of IMR in 2003 but the data is very preliminary. Therefore, given our goal to decrease it, the annual performance objectives for the following years (2004-2008) were re-calculated based on the final data reported for 1999-2002.

a. Last Year's Accomplishments

The overall infant mortality rate for 2003 was 8.5 per 1000 live births, while the white rate was 6.7 and the black rate was 17.5. The gap between races continues to narrow due to rising white rates and decreasing black rates. Analysis of birthweight and age of death continues to demonstrate the most important contributor to preventable death rates is preterm birth of a very low birthweight baby. The second contributor continues to be deaths to normal birthweight babies during the postneonatal period.

Fourteen FIMR teams reviewed cases in their local communities and provided data for a state database. A FIMR report was produced that aggregated data for the first time. A state advisory committee was also formed to oversee and set direction for the program. Additional funding was received to allow support to communities for case abstraction, to allow continued development of a new MS Access data collection system and to complete the process of cleaning up existing data. A training was also held in November for FIMR coordinators, abstractors and home interviewers.

A pilot preconception care program was implemented in one county with high infant mortality rates. The program identifies families with a fetal death or an early infant loss, provides crisis grief counseling and home visiting with interconceptional risk assessment, counseling and support to help improve outcomes for the subsequent pregnancy.

Safe Sleep Work Group convened to gather current state information about the dangers of sleep related deaths in infancy. A final report was produced in December 2004, making recommendations to state agencies to reduce the incidence of infant deaths.

MDCH received federal funding for Closing the Health Gap in Infant Mortality and began with strategic planning in Genesee County to determine where the funds would best be used to reduce the African American infant mortality rates.

Because of the racial disparity in infant mortality, the Infant Mortality Initaitive is targeting black mothers, specifically those living in eleven urban areas across the state with the highest Black IMR (BIMR) and the largest black population. Black mothers at risk have the following characteristics: unplanned pregnancies, unmarried, less than a high school education, smoking, inadequate prenatal care, and low income. In 2003, there were 22,380 live births to black mothers and 391 infant deaths. About 52% of the black deaths occurred in the city of Detroit.

MDCH met with key stakeholders from the eleven urban areas to discuss strategies for improving the BIMR in their area. Among the collaborators were local health departments, hospital perinatal physicians, the Michigan Coalition for Maternal Child Health, university fetal medicine researchers, and Michigan State University Institute for Health Care Studies (IHCS). Initial priorities included reducing unintended pregnancies and improving early entry to prenatal care.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided technical assistance and consultation to FIMR teams in 14 communities				X
2. Implemented pilot preconception care program in one county		X		
3. Convened Safe Sleep Work Group				X
4. Targeted prevention efforts in urban areas with highest black IM rates		X		
5.				
6.				
7.				
8.				
9.				

10.					

b. Current Activities

Local FIMR teams are incorporating a new data abstract form and new home interview tool designed to collect important information that is sent to a statewide database. A priority for the year is beginning to find places where FIMR information can be utilized to inform the broader Infant Mortality Initiative.

Funding is being provided through the end of this fiscal year to two counties with high black infant mortality rates to form a FIMR team.

The Safe Sleep Work Group concluded with an agreement to continue the process of assuring adoption of the recommendations through the appointment of an Interagency Implementation Team. The goals of this team are: 1) secure funding to support the recommendations; and 2) develop a strategic plan to implement the recommendations statewide. This implementation team began meeting in April with an aggressive agenda.

· Every Baby Is Placed To Sleep In A Safe Environment! This should be the core message of all educational presentations.

A Michigan Safe Sleep web site will be created with links to the program technical advisors and contractors. The state is also amending the child-care licensing rules to require Safe Sleep training of child care providers. All programs that deal with infants, mothers, families, and caregivers need the consistent language on Safe Sleep. A proposal is underway for the professional education component.

The Closing the Health Gap in Infant Mortality grant is using the resources to develop the AFRICAN Resource Center in Flint and to implement a referral/information "hotline", hire and train Patient Navigators to carry out AFRICAN activities. A systems map of medical and social services will be developed with referral protocols and "tool kits" for information dissemination. Non-traditional outreach will begin to identify at-risk African American women. Navigators will assess social issues and provide families with needed information and advocacy.

Healthy Michigan funds (tobacco tax) are being used to begin a new Infant Mortality Initiative. An internal steering committee has met to strategize what gaps exist, how to allocate the funds and to monitor components of the overall plan. The goals of the project are to empower local coalitions of key stakeholders to address the problem with locally based interventions with technical assistance and direction from MDCH. The eleven communities with racial disparities in infant mortality have been brought together in a network to learn from each other. Two additional staff are being hired to facilitate the coalition development, and manage the programs in existence to reduce infant mortality.

c. Plan for the Coming Year

Efforts as described above, targeting black infant mortality, unintended pregnancy, low birth weigh and preterm birth will continue.

State Performance Measure 2: *Maternal mortality ratio in Black women*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*					
Annual Objective and					

Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		6.4	17	16	26.4
Annual Indicator	16.6	17.0	27.0	35.7	80.2
Numerator	4	4	6	8	18
Denominator	24069	23494	22248	22380	22439
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25.7	36	35	35	34

Notes - 2002

The number of maternal deaths in Black women is too small to statisitcally calculate a rate or a ratio. The ratio generated by the system based on the number for the numerator would have a very large variation and can not be compared to the ratio in other years. Data for 2002 is not available at this time.

Notes - 2003

The annual performance objectives for the following years were re-calculated based on the final data reported for 1999-2002 given that 2003 is very preliminary (both, the numerator and the denominator).

a. Last Year's Accomplishments

The new case ascertainment method described in last year's report has proven to be an important case finding tool: eighty four additional cases were identified for the years 2001, 2002, and 2003.

As described in the Plans for the Coming Year in last year's application, both, pregnancy related and non-pregnancy related cases are reviewed. While Medical Committee continues to review the pregnancy related deaths, those non-pregnancy related are reviewed by the Injury Committee. Injury Committee expertise includes judicial representation, state police and highway safety representation, urban public health nursing, domestic violence, substance abuse as well as obstetricians. De-identified case information is available for use in conducting the reviews. Cause of death and contributing circumstances were identified for each case during the reviews with the focus on civic and health care system failures. Each review is followed by recommendations for prevention.
De-identified findings are also used for medical education, Grand Rounds, and other oral and written presentations.

Not described in plans in last year's application but accomplished is the development of a maternal mortality database offering more comprehensive case information for retrospective analysis. This database will house all information from the reviews not available otherwise.

For many years, the primary indicator of maternal health has been the maternal mortality ratio (MMR). However, mortality is the ultimate outcome of uncontrolled morbidity and women who deliver a live birth experienced either a new medical condition or the aggravation of a previous condition, which influence long-term health and mortality. The contribution of these health conditions to the disparities observed in the maternal mortality ratio needs to be further

explored.

A linked file of 1995-2001 Michigan Hospital discharge (Michigan Inpatient Data Base=MIDB) data with Michigan's residents' live births records has been developed. MIDB is a claims-based file, which uses International Classification of Diseases, Ninth Revision (ICD-9. Clinically related ICD-9 codes were grouped into pregnancy-related and non pregnancy-related categories. Our preliminary analysis, limited to hospitalized primiparous women with singleton births, showed that 384,179 women met the inclusion criteria. The most prevalent non pregnancy-related conditions and their racial distribution (black/white ratio) include asthma (ratio=1.72), hypertension (ratio=1.73), and cardiac diseases (ratio=0.67). Among the pregnancy-related conditions, the most prevalent and their racial distribution were hypertensive disorders of pregnancy (ratio=1.41), gestational diabetes (ratio=0.88), and abruptio placentae (ratio=1.41).

Understanding maternal health issues (maternal morbidity) is necessary to adequately address the mortality.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented new case ascertainment method				X
2. Developed a maternal mortality database				X
3. Developed a linked file of hospital discharge data with live birth records				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Maternal deaths identified from 1999 to 2003 were identified through the linked file and they were pregnancy associated (all causes, pregnancy-related and non-pregnancy-related).

By using the new ascertainment method, 23 maternal deaths to Black women were identified. This resulted in a maternal mortality rate for Black women of 102.8. The maternal mortality rate for White women in 2003 was 36.3, leading to a Black/White ratio of 2.8. The Black/White maternal mortality ratio in the previous four years varied from the lowest of 1.8 in 1999 to the highest of 3.7 in 2002 (1.8 in 1999,3.2 in 2000, 3.1 in 2001, 3.7 in 2002).

Comparisons are difficult with the cases identified just from hospital reporting prior to 1999 (cases reviewed prior to 1999 are not available in an unique accessible electronic file). It is also difficult to take any conclusion about the above recorded fluctuations in the Black/White ratio given the retrospective aspect of the ascertainment method developed. Besides, the maternal deaths for which pregnancy ended in a fetal death were reported by hospitals and not identified from the linked file, leading to potential underreporting.

Leadership for maternal mortality surveillance and analysis of maternal death data continues to occur from Maternal Child Health Epidemiology in collaboration with program staff. The MCH Epidemiology Unit continues to work with Vital Records and Health Data Development Section where the linkage is performed to update and improve the file. Also, the data have been shared with researchers from Centers for Disease Control and Prevention (CDC) and Missouri Department of Health and Senior Services under special agreements and just for the purpose of epidemiological studies. While the study in collaboration with CDC will explore the distribution of preterm labor and its impact on pregnancy outcomes, the study with Missouri is about the effect of interpregnancy interval on labor dystocia.

Case reviews by the Injury Committee and by the Medical Committee are occurring as described earlier. Findings from reviews continue to be entered in the MMMS database developed (mentioned in section a).

As described in plans in last year's application, a process of consensus building about recommendations from the Medical and Injury Committees is being used in a joint meeting of these committees scheduled for June (2005). Recommendations will be prioritized in order to be further translated into actions. Individuals and organizations will be identified in order to begin the process of designing implementation actions for the priority recommendations.

The fact sheet about maternal mortality in Michigan will be updated and released to increase the awareness among women's health care providers. During 2005, an annual report on Maternal Mortality will be developed, reflecting current status of the problem, current work being done, including the recommendations for prevention selected for further actions.

c. Plan for the Coming Year

Case reviews by the Medical Committee and by the Injury Committee as described earlier will continue. Findings from reviews will continually be entered in the MMMS database developed (mentioned in section a), thus allowing for further epidemiological studies to better understand and address the Michigan' specific issues.

The thorough review of maternal deaths might identify specific issues that would need to be further addressed by specific actions such as registries for rare and not well-known health conditions. Continued collaboration with Maternal Mortality Surveillance project at Centers for Disease Control and Prevention, Division of Reproductive Health to increase the expertise as well as to better understand the causes associated with this disturbing sentinel event will be always considered. Partnerships and collaboration with researchers and physicians interested to explore maternal mortality will be established.

As described in plans in last year's application, a process of consensus building about recommendations from the Medical and Injury Committees is being used in a joint meeting of these committees scheduled for June (2005). The Interdisciplinary Committee meeting will be held once or twice a year depending on the number of cases reviewed. It is expected that recommendations will continue to be prioritized and further translated into actions. Individuals and organizations will be identified in order to begin the process of designing implementation actions for the priority recommendations.

During 2006, the annual report on Maternal Mortality reflecting current status of the problem, current work being done and recommendations will continue to be disseminated. The fact sheet about maternal mortality in Michigan will be updated and released to increase the awareness among women's health care providers.

Also, an evaluation of the entire new maternal mortality surveillance process in Michigan will be planned by the end 2006.

State Performance Measure 3: *Percent of low birthweight births (<2500 grams) among live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		6.6	6.5	8.1	7.9
Annual Indicator	7.9	8.0	8.0	8.2	8.3
Numerator	10706	10714	10403	10778	10700
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.8	8.2	8.1	8	7.9

Notes - 2003

The annual performance obejctives were re-calculated based on the final data reported for 1999-2002, given that 2003 data is very preliminary.

a. Last Year's Accomplishments

Preliminary data from 2004 shows a total LBW rate of 8.3%. Typically the rate for black births is twice the rate for white births. Measures to reduce this rate have failed to be successful in the last 10 years. Some interest has been focused on substance abuse related to low birth weight. Smoking cessation and FAS prevention programs are active in recruiting pregnant women to reduce their risks.

Preconception counseling is also recommended for MSS/ISS clients, Nurse Family Partnership clients, and in the Pilot Preconception Program to reduce before pregnancy begins.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided smoking cessation services and supported tobacco quitline		X		
2. Implemented and monitored the progress of FAS prevention program to target high-risk families		X		
3. Continued MSS/ISS program that targets high-risk pregnant women		X		

and infants				
4. Continued MSS/ISS collaboration with WIC to identify clients and improve nutrition and weight gain		X		
5. Initiated complete redesign process for MSS/ISS with the goal of a more effective Maternal Infant Health Program				X
6. Piloted the Preconception program in Kalamazoo		X		
7. The Infant Mortality Iniative was proposed to address the disparity in LBW African-American infant in Michigan				X
8. Nurse Family Partnership program began enrolling clients		X		
9.				
10.				

b. Current Activities

The CDC funded Fetal Alcohol Syndrome Prevention Program in Detroit hired staff and had grantees meetings to collaborate on strategies for prevention. Much outreach has been done in Detroit with the result that many local agencies will be identifying at-risk women for the project. The pilot Preconception Project is finding good acceptance with women who have had an early pregnancy loss. The goals are to provide grief support and preconception counseling for subsequent pregnancies.

The MSS/ISS program is seeing good collaboration with WIC to identify clients and to improve nutrition and weight gain, two factors associated with low birth weight. The Smoking Cessation program continues to support a tobacco Quitline that helps many women reduce or stop smoking during pregnancy.

c. Plan for the Coming Year

The Infant Mortality Initiative will address reducing low birth weight as a measure of improving the health system of local communities. Each area will use collaboration between agencies and consumers to plan for improving the incidence of low birth weight in their area.

State Performance Measure 4: *Percent of preterm births (<37 weeks gestation) among live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		9.1	8.8	11.2	11.1
Annual Indicator	10.9	11.3	11.3	11.2	10.0
Numerator	14833	15017	14625	14651	12862
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or				Final	Provisional

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	11	10.9	10.9	10.8

Notes - 2003

The annual performance objectives were re-calculated based on the data reported for 1999-2003.

a. Last Year's Accomplishments

The percent of preterm births in 2003 was 11.2%. There has been no appreciable change in this statistic for many years. Though factors that contribute to increasing rates of preterm births are recognized, there has been no effective strategy to date to improve the problem. Each of the programs addressing prenatal care has an emphasis on prevention of preterm delivery. Healthy Start projects are active in 5 areas across the state. Nurse Family Partnership is active in 4 communities.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Provided technical assistance to Healthy Start projects				**X**
2. Continued the MSS program that targets high-risk pregnant women	**X**			
3. Piloted the Preconception program with emphasis on adequate pregnancy intervals		**X**		
4. Nurse Family Partnership encourages early enrollment to provide education on preterm birth		**X**		
5. Continued to analyze statewide FIMR data and inform programs on characteristics associated with prematurity				**X**
6. Sponsored and supported trainings and conferences that address problems associated with prematurity				**X**
7. The Infant Mortality Initiative that was proposed will charge communities with assessing gaps in service and developing local education efforts and health system plans to decrease preterm delivery rates and improve pregnancy outcomes				**X**
8. Initiated the redesign of MSS/ISS with the goal of a more effective maternal and infant health program				**X**
9.				
10.				

b. Current Activities

The SIDS/OID program sponsors a professional training annually that addresses common problems associated with infant mortality, such as prematurity. The training in 2005 hosted over 100 nurses and social workers across the state. Similar topics are covered in conferences held annually by the Healthy Mothers, Healthy Babies Coalition.

An Infant Mortality Initiative began this year charges local communities with assessing the gaps in service for the health care system for prenatal care and delivery. Part of the process is focus group evaluation of needs of local consumers and providers around such issues as prematurity

and early infant loss.

c. Plan for the Coming Year

The new Infant Mortality Initiative will reach full capacity in 2006. The eleven participating communities will develop local education efforts and health system plans to decrease the preterm delivery rates and improve pregnancy outcomes in their area.

State Performance Measure 5: *Percent of live births resulting from unintended pregnancies.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		37.7	40.1	39.6	39.2
Annual Indicator	37.5	40.6	43.1	41.2	39.3
Numerator	51015	54098	55882	53910	50410
Denominator	136048	133247	129518	130850	128271
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	38.7	38.7	38.3	37.8	37.3

Notes - 2002

No data is available for the year 2001 and 2002.

Notes - 2003

In 2000 the numerator considered was from PRAMS and therefore the percent was lower when the total numer of live births was used as denominator.
The calculation for 2001 considered the percent estimated by
PRAMS and the numerator was calculated based on the total live births reported.
The targets for 2002-2008 were changed based on the data reported for 1999-2001.

a. Last Year's Accomplishments

Most recent available PRAMS data (2002) indicates 43.2% of pregnancies in Michigan are unintended. The Teen Pregnancy Prevention Project (TP3), funded with Temporary Assistance for Needy
Families (TANF) bonus award funding, provided a third year of bonus funding to four communities selected through performance reviews and reductions in births within the targeted population during FY2003.. The four communities were: Flint (Genesee County), Benton Harbor (Berrien
County), Muskegon (Muskegon County, and Jackson (Jackson County).
All prenatal programs have a service component that connects women postnatally to family

planning services, either the Title X program or their medical provider. Prevention of unintended pregnancy is the responsibility of both partners. Many programs are beginning to highlight the responsibility of the male. Sterilization service has been expanded to focus on male clients as well. Michigan currently has one agency providing sterilization service statewide. This agency provided 1,588 sterilizations during CY 2004.

Reflecting the adolescent population where greater than 70% of pregnancies are unintended, an objective of the Family Planning Program is to assure that the percentage of teens served in the program compared to total users is at least 30% of the caseload; this objective was met last year. In 2004, 53,770 male and female teens were served in Family Planning Clinics.

The Family Planning Program also provided support to the Michigan Abstinence Program (MAP), so that preteens, teens and parents can be educated about abstinence. The MAP program aims to positively impact adolescent health problems by promoting abstinence from sexual activity and related risky behaviors such as alcohol, tobacco, and other drugs. During FY 04, there were 12 funded community agencies. The target population of MAP is 9-17 year old
youth (up to 21 years of age for special education populations) and their parents. During FY 04, MAP programs across Michigan served 16,701 youth. Of
these youth, 11833 received intense intervention (14 hours of more). In addition, 641 parents received information and education regarding how to talk with their children about sexuality and the benefits of abstinence.

School-based/linked health centers continue to be included in strategies to reduce unintended pregnancies. Michigan currently funds 31 school based/linked teen health centers to provide primary health care, psycho-social service, health promotion/disease prevention education, and referral services to youth 10-21 years of age. MDCH received approval from the Center for Medicare
and Medicaid Services (CMS) in March 2004 to match the $3.74 million in Teen Health Center funding. Implementation details for this outreach match are now being developed.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implemented Teen Pregnancy Prevention Project		X		
2. Provided Family Planning services statewide	X			
3. Implemented Michigan Abstinence Program		X		
4. Provided education and referral services through school-based services		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In 2004, 174,654 women and 5,585 men were served in Family Planning Clinics. Although this represents a reduction of 4.3% in women served and 23.2% in men served, a result of state budget and funding constraints, a process of dialogue led by MDCH with providers to look at the allocation process and opportunities to maximize revenue is occurring. Michigan Department of Community Health(MDCH) submitted a Section 1115 Family Planning Waiver to

the Centers for Medicare and Medicaid Services (CMS) in October 2004. Approval of this waiver will provide Family Planning services coverage to women of childbearing age who are not on Medicaid and whose family income falls at or below 185% of federal poverty guidelines.

The Michigan Abstinence Program (MAP) projects and school-based/linked health centers continue in the current year as described in the previous section.

c. Plan for the Coming Year

Maximize use of Family Planning Program funds to serve as many individuals as possible in these programs, especially for low-income population. Continue to monitor for 30% teen users of services. Assure that Family Planning clinics are held at times are convenient for teens. Increase the number of individuals served through the Section 1115 Family Planning waiver. Continue current MAP projects through FY 07.

Through increased funding obtained through federal Medicaid matching dollars, use additional centers as funded through the School Based/Linked Health Center program with a goal of providing primary medical services to an increased number of at-risk children.
Maintain the statewide Maternal Support Services program and four funded sites for the new initiative, the Nurse Family Partnership including components to provide reproductive health information and assist women served to make choices about birth control methods.

State Performance Measure 6: *Percent of repeat live births to unwed mothers 15-19 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		16.6	16.0	16.2	17.3
Annual Indicator	19.7	16.4	18.9	17.6	18.2
Numerator	2395	2210	2019	1887	1965
Denominator	12177	13438	10670	10747	10813
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.1	16.9	16.7	16.5	16.5

Notes - 2003

The annual performance objectives for 2004-2008 were calculated based on the data reported for 1999-2003.

a. Last Year's Accomplishments

Michigan received in FY 2001 a SPRANS Abstinence Education Grant to implement the research based Teen Outreach Program (TOP) without the comprehensive sex education component. Four communities received the final grant year of these funds: Arab-American and Chaldean Council (Detroit), Kent County, Muskegon County, and Shiawasee County. MDCH applied for additional SPRANS funding to continue the Michigan Teen Outreach Program.

Opportunity to increase access to family planning services is being sought through a waiver application. MDCH has included family planning as part of an adult benefit waiver which was submitted in October, 2004 to the Centers for Medicare and Medicaid Services (CMS) to extend eligibility for Medicaid family planning services to women of childbearing age who are not currently on Medicaid and whose family incomes fall below 185% of the poverty guidelines.

An additional opportunity to provide more accessible Family Planning services is occurring in southeast Michigan is due to Wayne County Health Department's reapplication to provide Family Planning services for adolescents and adults. This application is currently under review. Services are currently available through the Teen Health Center.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assured Family Planning services as needed to Michigan residents	X			
2. Initiated waiver application to extend eligibility for Medicaid family planning services				X
3. Assured Family Planning services for the target low-income population	X			
4. Assured that at least 30 percent of Family Planning users are teens	X			
5. Began targeting of high-risk areas to make Family Planning more accessible	X			
6. Continued the service learning and abstinence education activities of the Michigan Abstinence Program		X		
7. Continued to provide health services to adolescents through teen health and school-based/linked health centers	X			
8.				
9.				
10.				

b. Current Activities

Strategies described under NPM #8 and SPM #5 are also directed to reduce repeat live births to unwed mothers 15-19 years of age. The statewide Maternal Support Services program and four funded sites for the new initiative, the Nurse Family Partnership, include components to provide reproductive health information and assist women served to make choices about birth control methods.

Maintain the availability of Family Planning services.

Through increased funding obtained through federal Medicaid matching dollars, 13 additional clinical and 4 additional non-clinical centers have been funded through the School Based/Linked Health Center program with a goal of providing primary medical services to an increased number of at-risk children.

c. Plan for the Coming Year

Current activities will continue in 2006.

State Performance Measure 7: *Increase the percent of CSHCS beneficiaries enrolled in a managed care Special Health Plan*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		20.0	35.0	30	30
Annual Indicator	7.1	13.2	28.0	30.0	22.3
Numerator	2045	4270	5664	6293	5320
Denominator	28908	32303	20250	21000	23817
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	0	0	0	0	

Notes - 2002

The denominator for 2002 is changed to only those CSHCS-enrolled persons living in counties with an active SHP. The previous denominator included all CSHCS-enrolled persons, whether or not an SHP was available to them.

a. Last Year's Accomplishments

After six years the Special Health Plans (SHPs) completed their final year of operation. The decision was made to terminate the SHP contracts effective October 1, 2004. The State was instructed to apply the federal requirements regarding Medicaid HMOs to the SHPs. This change would have resulted in a significant change to the SHP design and operations as established for children with special needs. In addition, CSHCS did not have the resources to establish and maintain the type of oversight required under those particular federal requirements.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. This performance measure is discontinued.				**X**
2.				

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Michigan terminated the SHP contracts effective October 1, 2004. This decision was due to federal requirements to revise the SHPs to operate within the parameters of Medicaid HMO. This would result in the loss of many of the unique features in the SHP model. In addition, we do not have the resources to monitor the SHPs under the federal requirement. We are completing the final cost settlement process with the parent organization of the SHPs.

c. Plan for the Coming Year

Redevelop the Michigan Medical Home Model for CSHCN outside of the managed health care design. This measure is discontinued.

State Performance Measure 8: *Increase the utilization of dental services by CSHCS beneficiaries (CSHCS reimbursed)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective		20.0	15	16	17
Annual Indicator	14.9	14.0	14.3	15.2	16.7
Numerator	4320	4508	5060	5164	5747
Denominator	28908	32303	35364	33863	34452
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	18	19	20		

a. Last Year's Accomplishments

This performance measure was chosen at a time that CSHCS was in a position to focus on dental services specifically. Since that time dental care for the adult CSHCS population has been eliminated and other deficit reducing actions are being considered regularly. No efforts

were made last year to address this measure. This measure is discontinued.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This measure is discontinued.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 18: *Increase the percent of Medicaid enrolled children, 0-6 years of age, who receive lead screening*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		4.3	4.3	25	25
Annual Indicator	17.9	19.9	17.7	18.8	47.3
Numerator	52946	61914	58574	65078	167839
Denominator	296312	310516	330421	346239	354928
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	70	80	85	90

a. Last Year's Accomplishments

There was a major increase in the number of children 0-6 years of age who were tested in 2004. More than 25,000 additional children were tested over the number for the previous year. Slightly more than 3,000 children were found to have blood lead levels at or above 10 ug/dL, but the percentage of children tested with elevated levels dropped to 2.2%, just slightly above the national average. The state has been divided into ten regions, and a case manager responsible for followup of any child with a blood lead level of 20 ug/dL has been identified in each region. Special reporting requirements have been developed for Regional Case Managers, and they meet monthly with Childhood Lead Poisoning Prevention Program staff to discuss issues of concern and review of data and activities. The Regional Case Managers have three major responsibilities: followup as described above; implementation of strategies to increase testing; and, the development and implementation of a primary prevention plan addressing the needs of the entire region. In addition to special consultation with the City of Detroit Health Department, twelve other communities (Battle Creek, Benton Harbor, Flint, Grand Rapids, Hamtramck, Highland Park, Jackson, Kalamazoo, Lansing, Muskegon, Pontiac and Saginaw) are identified as high-risk and receive increased consultation and services. Funding from the Centers for Disease Control and Prevention and the Healthy Michigan Fund (state dollars) support for coalition-building and grant development, door-to-door educational activities and these will be the first communities to assist in the roll-out of the public awareness campaign that was identified as one of the first seven priorities of the Governor's Task Force on Elimination of lead poisoning in young children. The Task Force report was officially accepted by the Governor in November 2004; several pieces of legislation spawned by the report were passed by the legislature and signed by the Governor, and one million dollars in state General Funds were allocated, although activities related to the funds did not begin until early 2005. Several activities have contributed to the increase in testing in 2004, including: A letter signed by the Surgeon General sent to all providers of pediatric care identifying the requirements for Medicaid testing and the CDC and AAP recommendations for testing of children at high risk; the implementation of a website developed to assist providers in identifying children at highest risk; the implementation of a "pop-up" in collaboration with the Michigan Childhood Immunization Registry; a new Public Act signed into law requiring the Medicaid Health Plan providers to increase testing; development of geocoded maps to assist health plans and local health departments in outreach activities; and, many presentations and displays at conferences attended by health care, education, construction and abatement professionals.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased the number of children tested by 25,000	X			
2. Provided consultation to high risk communities				X
3. Participated in and supported Governor's Task Force				X
4. Notified providers of testing requirements for Medicaid and AAP recommendations				X
5. Implemented a website to assist providers in identifying children at highest risk				X
6. Developed a pop-up screen reminder re: lead testing in collaboration with Michigan Childhood Immunization Registry				X
7.				
8.				
9.				
10.				

b. Current Activities

Continued collaboration with local health Departments, Medicaid Health Plans, Regional Coordinators and a variety of other stakeholders representing the departments of Education, Environmental Quality and Human Services, the Michigan State Housing Development Authority (and other housing authorities throughout the state), parents, advocacy groups and health care, education and construction professionals to provide information, consultation and technical assistance. We also seek the expertise of these individuals and groups as educational materials are developed to increase awareness and concern regarding childhood lead poisoning.

c. Plan for the Coming Year

Activities are well underway to address the seven priority "first steps" identified by the members of the Governor's Task Force and the six subcommittees that supported the development of recommendations and strategies. Coalition-building and grant development assistance will be provided to seven of the thirteen targeted communities; case management is available statewide; the public awareness campaign will begin in June 2005; the lead-safe housing registry is in development; abatement of 15 homes (with another 10 planned) has been completed; an Ombudsman is available to families seeking assistance with obtaining resources for abatement; a Lead Commission has been named by the Governor and will hold it's first meeting in June or July of 2005 (with two public hearings to follow); and, the Public Health Trust recommended by the Task Force is under development and should be established within the next few months. While additional funding to expand these activities is not yet assured, it is likely that at least the same level of funding will be available to the department in 2005.

E. OTHER PROGRAM ACTIVITIES

The Department of Community Health provides a toll-free hotline for pregnant women (1-800-26-BIRTH and 961-BABY in Detroit-Metro area) and for children with special health care needs (1-800-359-DSCC; T.D.D. #1-800-788-7889). 1-800-26-BIRTH is the primary source of information about health care services available under Titles V and XIX and WIC. This line includes information on immunizations and referral to local health departments and other providers for service. All numbers are coordinated interdepartmentally both at the state and local level.

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as crisis calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid identification card to each recipient and in AFDC warrants. In FY 2004, 7,730 calls were handled by the 1-800-26-BIRTH hotline.

The Children's Special Health Care Services Family Phone line, operated out of the Parent Participation Program (PPP), is a toll free number for families to communicate with CSHCS staff (at state and local levels), other agencies serving children with special needs (e.g.; genetics counseling centers, newborn screening), providers and other families. The Family Phone Line can be used to: obtain general information about CSHCS, contact the Family Support Network, resolve problems related to CSHCS, contact the Michigan SIDS Center for support services or information, and ascertain the status of their application or renewal paperwork. This number is used to refer families to local health departments. The number is also publicized at local parent group meetings, CSHCS presentations throughout the state, and is included in the CSHCS brochure, Familiy Support Network brochure, and the newborn hearing brochure. PPP recently published a new Family Guide of CSHCS

which also inlcudes the toll free number. Family Phone Line calls are compiled and analyzed by PPP quarterly to determine areas of special concern to families and to identify needed policy or procedural changes. In 2004, 31,934 calls were handled by the Family Phone Line.

F. TECHNICAL ASSISTANCE

We have not identified any technical assistance requests at this time.

V. BUDGET NARRATIVE

A. EXPENDITURES

On Form 3 line 3, Form 4 line I.d and Form 5 line II, Expenditures in 2004 reflect the increased caseload and expenditures for Medical Care and Treatment for Children with Special Health Care Needs.

An increase in expenditures for 2004 is due to increased fees approved for Newborn Screening to fund the updated technology and additional tests and increased formula rebate in the WIC program (form 3 line 6, Form 4 line I.b, and Form 5 line III).

On Form 4, the decrease from the budgeted amount to the expended amount in 2004 for Children 1 to 22 years old is due to the transfer of funds for the MOMS program to the Medical Services Administration (prenatal services for low-income women who do not qualify for Medicaid). Also on Form 4, the difference between Budgeted and Expended amounts for "Others" reflects the difference between the draft appropriations bill and the final actual appropriations.

B. BUDGET

In FY ‘89, the maintenance of effort amount was $13,507,900. This amount represented state funds spent for Children with Special Health Care Needs, family planning, adolescent health, local MCH programs, and WIC.

The projected match for FY ‘06 is $38,993,900. In addition to state general fund monies, the federal-state block grant partnership includes program income from the WIC and newborn screening programs, and Children's Trust Fund monies supporting the CSHCS program.

Other funding sources that contribute to our MCH priorities include Medicaid (not included in this partnership agrement), Abstinence Education, WIC, Ryan White funding, Title X of the Public Health Service Act, and other grants from CDC and HRSA.

On Form 3 line 3 and Form 4 line I.d, the budget amount for 2006 reflects the increase in caseload and funding for Medical Care and Treatment and the elimination of services for adults in CSHCS (hemophilia and cystic fibrosis) as contained in the Executive Budget. On Form 3 line 6, the increase in Program Income includes additional funding from the WIC formula rebate and an increase in fees for newborn screening. On Form 4 line I.c, the 2006 budget reflects the transfer of the MOMS program (prenatal care services for women who do not qualify for Medicaid) to the Medical Services Administration. Finally, on Form 5 line III, the 2006 budget figure includes the increases in WIC formula rebate and newborn screening fees.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.